Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:00 AM **Physician** 2005 June Catherine Davies /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Genesis Eldercare, Spa Creek Center Annapolis 8. Date of Birth (Month, Day, Year) Sept. 16,1929 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🛱 F Maryland 75 Yrs. 212-26-3757 Sept. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a, State "natural", or itams 23a or 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, Its Madical Examinational Legical angones. 1XXYes 2 No Annapolis Director Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 United States 1016 Van Buren Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 11 Marital Status Black, White, etc. 1 □ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No Specify: altimore, Maryland 21215-0036 þ 3XX Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Casciero Anthony Busto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31 Rockwell Court Annapolis, Maryland 21403 Iva Frantz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 W Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 6/24/2005 Annapolis, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses Much Annapolis, MD 21401 147 Duke of Gloucester St. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Friysician /Medical Due to pras a consequence of): **Examiner** redia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Haknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 1 ☐ Yes 2 ☐ No this certificate or Attanding Physician: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ို I Diractor: After the 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No death. investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funaral I Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar

2005

29b. Signature and title of certifier

m.D 32. Resistrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 5:50 P **Physician** Helen Elizabeth DiCarlo June 19, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arundel Medical Center Date of Birth (Month, Day, Yea 3-3-1923 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1□M 2XF Months Maryland Director 577-22-8277 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or than "natural", or Items 23e or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "natural", or Items 23e or 2 any injury or other traumatic excess USA 21037 1429 Shore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Viola Latimer George Edward Clubb 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1429 Shore Drive, Edgewater, MD 21037 James E. DiCarlo/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition WBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 6-22-05 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signiture of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Zweere Priysician preumonia disease or condition resulting in death) /Medical Fue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Iclan/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 DEctopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed ; page 2 should be det \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 Hospitel or Attanding Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 0 1 Tyes 2 No his 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Japiter L.
4 hours after dea.
-ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 - Homicide n 24 hours the Funaral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of 051819 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 132 Holiday CT suite 201 AnnapolisMozicus

State Registra

matteen

32. Register's Signature

31. Date filed (Month, Day, Year) JUN 2 2 2005

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. N6 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Physician June 20, АМ 4:45 Bernadette Alice Evans /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heritage Harbour Health Center Annapolis Anne Arundel If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 11–23–1927 If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 1 ☐ M 2 🖫 F 77 505-34-6389 Canada Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b County 10c. City, Town or Location 10a State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 238 21401 USA 2541 Painter Ct. Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Depritment of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or iten any injury or other fraumatic event, the Marical Examined once. 1 Never Married 2 Married ☐Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ð 3

Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alice Gale James McLennon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Lankford Rd., Harwood, MD 20776 Carolyn K. Marcian/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition to Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 6-24-05 Crownsville, MD □ Donation 5 □ Other (Specify) 21. Signatu / Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner lucy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No jo 4 Pregnant at time of death 5 Other (specify) the 9☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 Probably Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No newwork certificate has 1 ☐ Yes 2 No Hospitel or Attending Physicien: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of After Natural 2 Accident 5 Pending investigation after death. 2 No 1 Tyes 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely f (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier 0 D57028 and address of person who completed cause of death (Item 23a) (Type, Print) Aut. Ste. 231 Annapolis Chopra M.D. 600 Ridge

Registrar

State

			1 - For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	rtment of tificate of	Health an <i>Death</i>		Reg. No.	5 22504
	Physici	an	1. Decedent's Name (First, Middle, La Vincent Cornel:		nan Sr				2. Date of De. Month June	ath 18, 2005	3. Time of Death 4:20 A. M
	/Medio Examir		4a. Facility Name (If not institution, given	re street and numb	ber)		•	or Location of D		4c. County of I	Death
	×		Gladys Spellman 5. Social Security Number 6. Social Security Number		Center Age (In yrs.		Che	everly	Hrs. 8 Date of Bird		George's
	Funeral Director			1 XM 2 ☐ F	59	Yrs.	Months Days		Hrs. 8. Date of Bir (Month, Da 12/25/	45 W	Birthplace (State or Foreign Country) Ash., D.C.
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl a-f sho	tor	Md. P.G.			Distr	rict Heig	ghts			1¥ Yes 2 □ No
	death with the Maryland ms 23s or 28s-f show Finast be notified at	Director	10e. Street and Number 6051 Surrey Sq	uaro Iano			10f. Zip Code)747		10g. Citizen of Wha	,
	ns 23s	Funeral	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13. \	Was Decedent of	Hispanic Origin	? (Specify Yes or No	- 14. Race -	American Indian,
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yland	Menta Menta arked atic ev	To B	William Freeman					1	e Ruth Wal		
Mar	s 1 and 2 should 1 Health and Mer Item 27 Is marke othar traumatic		19a. Informant's Name/Relationship Donna Freeman/Wi						or Rural Route Numbe e,District		
Je,	es 1 and 3 of Health I Item 27 r other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from S	1 /	lace of Dispo cemetery, cren	sition (Name of natory or other pl	ace)	Date	20c. Location · Cit	y or Town, Stete
Baitimor	permit. Pages Department of t Important: If Its any injury or of		*4 □Donation 5 □Other (Special	fy)			Mem. Par		25/05		, Maryland
n	permi Departimpo sny ir	l.,	21. Signature of Funeral Service Lice	Plan	7	- Z	I.S.Wash 1925 Bur	ington a	& Sons Co.	,Inc. Washingto	on,D.C. 20019
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	cuted nd transit	Examiner	Sequentially list conditions, any, coding to influe date cause. Enter Underlying Cause (Disease or injury that initiated events	° — Dia	betes l	Mellitu	ıs				
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j.	at the de by the	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov							
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Hecords,	w require been sig	leted	Respiratory Fa	•	COLECT	Only			24a. Was		re autopsy findings available
	The law cate has page 2	Completed	Sepsis, Sacral		 ii				auto perfo	psy pric ormed? dea	r to completion of cause of th? Yes 2 € No
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	ar this on the direction	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time o	1 3 DOA 28c. Inj	ury at	ng Home 5 Resi 28d. Describe	dence 6 Other how injury occurred	(Specify)
Sion	Attending F death. ctor: After y the funera	atio	1 Avatural 5 Pending 2 Accident Investigation	on	, Day rear)	Injury		ork?]Yes 2□No			
Division of	al or Attend after death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Flace	of Injury - At h g, etc. (Special	ome, farm, str fy)	eet, factory, office	9		(Street and Number wn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (sis of examina				place, and due to the occurred at the time,		
	To th vithin To th comp	Me	29b. Signature and tute of certifier	1011	**			nse number		29d. Date signed (/	
	1	1	J. Jakaly	18 M		- 00c) T		0026024		June 20	, 2003
C	RU		30. Name and address of person who Lester Miles, N	1.D. 6490	Lando	ver Ro		e F, La	ndover, Ma	aryland 20	785
-	Sta Regist	ate	31. Date filed (Month, Day, Year) JUN 2 2 20	ns Re	gistrar's Sign	ature	19				

			For State Registrar	State of M	laryland /		artment rtificate				lental H	ygien	e e n n i	-	22505
		-	Decedent's Name (First, Middle, La.	st)							2. Date of D		200)	3. Time of Death
	Physici /Medic		Jessie L. Frohl	ich							June 2	20 , ິ	2005 °	ear	5:00 PM M
	Examir		4a. Facility Name (If not institution, give	e street and number,)		4b. City, T	own, or	Location	of Death		4	c. County of	Death	
			Anne Arundel Medi					napo		0.411			Anne		
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. last bi	irthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of B				lace (State or Foreign try)
	Director		Usual Residence of Decedent		_86			1			9-26-	1918		Mar	yland
	yland		10a. State 10b. County		10c. City, Tov									1	Od. Inside City Limits
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	or 28	Funeral Director	10e. Street and Number				10f. Zip 0	Code				10g. C	itizen of Wha	at Coun	try?
	a 23a	rai	3359 Easton Rd.			1		2103					USA		
	item item	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 🔀	?	13.	Was Decede If Yes, specif	nt of His ty Cuban	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - Black,	Amenc White,	
39	urs af	by F	3 € Widowed 4 Divorced	If Yes, Give Year or Dates:	NO		1 ☐ Yes 2	No K	Specify:				Specify:	Whi	te
21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-1 show dical Examiner must be notilied at	Completed	15. Decedent's Ed		16a	a. Deced	dent's Usual	Occupa	tion			16b.	Kind of Busir	ness/inc	lustry
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	ygien ygien rer th	Con	12th			_Ho	memake						Hom	e	
and	be fill hd ott	Be	17. Father's Name (First, Middle, Last) Jesse Edward								(First, Middl				
$\frac{2}{5}$	d Mer nark	2	19a. Informant's Name/Relationship (101	h 8.4-181-		(Canada)			R. Ba				
Maryland	d 2 sl th en t7 ie r traur										I Route Num	de e		ite, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examiner must be notified at once.		Mary E. Travers/ 20a. Method of Disposition	Daugnter	20b. Place of cemete	of Dispo	Easton (Name	on Ro	1., 1		ater,		Location - Cit	y or To	wn, State
Baltimore,	Pages ent of nt: if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specification)		Lakem				- 1	6-25	_05	Da	videor	x 7 + 1	le, MD
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m	Dependent of the control of the cont		allow to the												21037
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. Do	not ent	er the mode	of dying	, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. (aldi	ac	A	my	ton	ira					Onset and Death
15	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	0 ,	-	À -	$\overline{\Omega}$	0		y		
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	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):									
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Вох	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	n 3[Ectopic pred	anancy					23d. Date o	f delive	ry
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	signed to the	þ	Part II. Other significant conditions c	ontributing to death t	out not resulting i	in the ur	nderlying cau	usa givar	n in Part I.	*		Tobacco Yes :	_	ite to th ⊒Proba	e cause of death?
Orc	w requir been si should	etec	<u> </u>	·									2 140 3[
Records,	The law ate has I bage 2 s	Completed									24a. Wa auto	s an opsy formed?	24b. Wei prio dea	r to con	sy findings available apletion of cause of
a		e Co	OF Man and advantage and advan								1 Tes	2 Z N			2 □ No
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of	문 부 le		27. Manner of eath	28a. Date of Inju	iry 28b.	Time of		c. Injury : Work?			ne o∟ nes 28d. Describe			<i>эрөспу</i>)
0	Attending I ar death. ector: Alter by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear)	Injury	М		? es 2 🔲 !	No					
Division	r Atte	Certification:	3 Suicide 6 Could not be determined	289. Prace or in	ury - At home, fa	arm, stre	et, factory,	office		2	28f. Location City or To			or Rural	Route Number,
	ital or irs afte ret Dire														
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best niner: On the basis o and manner st	if examination ar	e, death nd/or inv	occurred at restigation, in	the time	, date an nion, dea	d place, a th occurre	and due to the ed at the time	e cause(, date ar	s) and manne nd place, and	er as sta due to	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier				29c. 1	License	number			29d. D	ate signed (A	Month, D	Day, Year)
							D	157	02	-0		6	120		
	1		30. Name and address of person who	completed cause of o	leath (Item 23a)	(Туре, І	Print)				A	0 -		Λ	4.0.
			7 DITE CLOP	RA 60	U KIC	len	true	ne	le	Si	ule !	1	51	-	Mopeli
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	ar's Signature	ا مع	1								
DH	MH 17 Rev 1/20			1000	A CONTRACT	-	GOOD!								
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State of Maryland / Department of Health and Mental Hygien 0 0 5 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician P M JUNE 16 2005 8:17 GLOVER BELL WILLIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner PRINCE GEORGE'S BOWIE BOWIE HEALTH If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1910 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Months 1 ☐ M 2 🖾 F Yrs. GEORGIA November 12 Director 258-46-1396 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No BOWIE MD PRINCE GEORGE'S Directo 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 3513 MABANK LANE 20715 U.S.A. Items 23a death by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Yes 2 No 1 □ Never Married 2 □ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: BLACK 3 X Widowed 4 □ Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: If item 27 Is marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT TEACHER 4 18. Mother's Name (First, Middle, Maiden Sumame) traumatic event, 17. Father's Name (First, Middle, Last) Be HARDY MARY MORRIS WITI. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3513 MABANK LANE BOWIE, MARYLAND 20715 PANKER/DAUGHTER SHERRY other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once. 6/25/05 OAKFIELD, GEORGIA CHURCH CEMETERY ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical use as the attending phy IF FFMALE If yes, outcome of pregnancy

1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9∏ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2€ No 1 ☐ Yes 2 🔀 No 1 🗌 Yes certificate the Hospitel or Attending Physicien: 26. Place of Death (Check only one) director 25. Was case referred to medical Be examiner' Other: 4. Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 N ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 🗌 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Mile of certifier 6/18/2005 D43351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6201 Greenbelt Rd Suite U-15 College Park, MD 20740 Ikechi Okwara M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 2 2 2005

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item#8, perfH, C845, 7/14/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 20, Troy Dante Greene June 2005 10:01 P.™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 2 → F 5. Social Security Number 7. Age (In yrs. last birthday). 2 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Yrs. 213-82-9994 |3/22/71 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo Md. P.G. Bladensburg 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 6010 Logan Way 20710 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 0 Never Married 2 Married Black Maryland 21215-0036 1□ Yes ZENo þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 12th College (1-4or 5+) Customer Service Representative Private Industry 2 should be filed was and Mental Hygier Is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elbert Smith Barbara J. Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 sl Health an Pages 1. Barbara J. Greene/Mother 6010 Logan Way, Bladensburg, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or once. Maryland Nat'l Mem. Park 6/25/05 Laurel, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019 21. Signature of Funeral Service Licensee 644 W-100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiomyopathy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, al director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Sepsis Deen Sickle Cell Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Renal Failure 1 Yes Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Injury 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 06-21-2005 D54347 30. Name and address of erson mpleted cause of death (Item 23a) (Type, Print) Neeraj Chopra, M.D. P.O. Box 83819, Gaithersburg, Maryland 20883 31. Date filed (Month, Day, Year) State JUN ? 4 2005 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Phy G845 7-20-05 tas
Certificate of Death

Reg. No. Reg. No 2. Date of Death 6 1. Decedent's Name (First, Middle, Last) Marien Doris Gilliam **Physician** Marjan /Medical 4a. Fecility Name, (If not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner mon H Some G 1 Washinton akoma 8. Date of Birth (Month, Day, Year) (Stategor Foreign Country)

April 26, 1935 Washington, DC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birth day) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 🕮 F Yrs. Director 577-44-2592 70 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Maryland Prince George Temple Hills Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 2225 Afton Street United States death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or ite ury or other traumetic event, the Medical Exertion 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 D.C. School Worker District Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Horace Settles Thelma Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2225 Afton Street, Temple Hills, MD 20748 Robert Gilliam/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Important: If any injury or ottes Maryland Veterans Cem. 6/24/05 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Licenses 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Ent I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat by a rest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnan Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 2 No 25. Was case referred to medical 1 Yes or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? : After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No athologically inta wever the ofping death. 2 Accident 1arch 1,2005 after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Bural Poute Number, City of Town, State) 2225 4770 57 28e. Place of Figury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my excitation death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a To the Funerel I 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Hr3 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 24

2005

32. Registrar's

			1 - For State Registrar	State of Ma		artment of He rtificate of D		lental Hygie		22500
	Physic /Medi		1. Decedent's Name (First, Middle, Las Alford Ha	,				2. Date of Death Month Jime	Day Year 2 3 1005	05 LOU AM
}	Exami		4a. Facility Name (If not institution, give			4b. City, Town, or L			4c. County of Death	
	Funeral		134 Warren D 5. Social Security Number 6. S		(In yrs. last birthday)	E1kto If Under 1 Year Months Days	n If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	Cecil 9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	*	75 Yrs.				,1929 к	
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	ith the Maryla or 28a-f shore	Director	10e. Street and Number	cil	Elkto	10f. Zip Code		10g.	Citizen of What Cour	
	s 23a		134 Warren Driv			2192			U.S.A.	
336	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show to Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	,	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	panic Origin? (Spe Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh:	etc.
Maryland 21215-0036	in 72 hours n "natural", Negleal Ex	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	- IIIA	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of worki	ng 16t	o. Kind of Business/Inc	
1212	TO 100 100 100		Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	tenance			DuPont Co) .
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Mary	nd 2 should be f lith and Mental H 27 is marked of r traumatic eve		19a. Informant's Name/Relationship (7	ype, Print)			d Number or Rura	l Route Number, Ci	ity or Town, State, Zip	Code)
	s 1 a f Hes item othe		Gladys Hamilton 20a. Method of Disposition		1200. Flace of Dispo	Warren I sition (Name of natory or other place)	rive.	Elkton,	MD 2192 Location - City or To	n, State
Baltimore,	Pa ant ury		1 ★ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify)	Gilpin	Manor	June	28,2005	Elkton	, MD
Ba	permit. Departi Importi any inj		21. Signature of Supera Service Licens		1	NamPadrakoress Andrew G	COOL	uneral	Home	
1	Pnysician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	a. Trosto	te Canceronsequence of):		ain St. such as cardiac of	respiratory arrest,		Interval Between Onset and Death
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	Due to (or as a o	consequence of):					
68760,	ificate be executed g physician and as the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a od.	consequence of):					
.O. Box	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ry Day Year
Records, P.	w requires that the dea been signed by the a should be detached to	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	derlying cause given	in Part I.	23e. Did tobacc	co use contribute to the	
al Reco	The law ate has b page 2 s	Completed						24a. Was an autopsy performed 1 Yes 2	? prior to com	sy findings available aptetion of cause of
of Vital	Physician: this certificral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	fospital:	2 ER/Outpatient	0.1	6. Place of Death			
ion of	To the Hospital or Attending Physimiting A hours after death. To the Funeral Director: After this completely filled in by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury at Work?		e 5 Nesidence 3d. Describe how in	6 ☐Other (Specify) njury occurred	
Division	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	et, factory, office	28	Bf. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	e Hospi 24 hour e Funer letely fill	Medicai	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of r ner: On the basis of ex and manner stated	amination and/or inv	occurred at the time, estigation, in my opini	date and place, ar on, death occurred	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ted. the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier			29c. License no	umber	29d. [Date signed (Month, D	lay, Year)
•	_		Tavku 30. Name and oddress of person who co	npleted cause of deat	h (Item 23a) (Type 5	915 Priot)	314	Ju	Date signed (Month, Due 24, 200	5
	5		HEURLAS MO	Susons	NorTher	n Wesa	peake 1	Hogrice, £	ikton, M	
	Sta Registra	~	31. Date filed (Month, Day, Year) JUN 2 7 2005	32. Registrar's	Sign fure			# 189		

	_	For State Registrar		Ce	rtificate of	Death	,	Reg. NO	005	225.10
sicia	n	Decedent's Name (First, Middle, Last) JOSEPH A. HENRY	7				2. Date of Dea Month JUNE	Day 22	2005	2:39 P
edica ımine		4a. Facility Name (If not institution, give s	treet and number)			or Location of Death	BOILE	_	ounty of Death	
		UNION HOSP		to a de la de la		If Under 24 Hrs.	0.000		CECI	
ral tor		5. Social Security Number 042–12–3936 6. Sex Usual Residence of Decedent	7. Age (In yrs. 87		Months Days	Hours Min.	8. Date of Birth (Month, Day July 20	, 19	17 Nev	place (State or Fore intry) V Jersey
4	1	10a. State 10b. County	10c. Ci	ty, Town or L	ocation					10d. Inside City Lim
	to	Maryland Cecil	L		Elkt	on				1 X Yes 2 □ I
	Director	10e. Street and Number	_		10f. Zip Code	1001		10g. Citize	on of What Cou	intry?
To a		1 Price Drive	2. Was Decedent Ever in U	IS 13		1921	ecify Yes or No-	14	USA Race - Amer	ican Indian
	y Funerai	1 Never Married 2 Married	Amed Forces? 1∑Yes 2 □ No If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
	d by	3 N Widowed 4 □ Divorced	Year or Dates: unkr		dont's Havel Ossue	nation				
	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	pation during most of work d)	ring	16b. Kind	of Business/Ir	noustry
	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		resident			Ins	surance	Company
	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden S	umame)	
	2	George Washington				Olive				
		19a. Informant's Name/Relationship (Ty) Caledonia L. Henry			_	and Number or Rui		-		
		20a. Method of Disposition	20b.	Place of Disp	osition (Name of	1.2	Date T		ation - City or T	
		1 ☐ Burial 2 🏋 Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)			matory or other pla	, Inc. 7	/1/05		Cheste	
once.	Ì	21. Signature of Funeral Service License	90	2	2. Name and Addre	ss of Facility	1		-	
a		Star Di	<i>stt</i>		552 L	wis Stroc	ral Hom	e, P.	Grace.	MD 21078
		21. Signature of Funeral Service License Servi	cations that caused the dea e cause on each line.	th. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	32300	MD 21078 Approximate Interval Between
n		disease or condition		HYPEK	KALEMIA					Onset and Death
ai er		resulting in death)	Due to (or as a conse	quence of):						
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	by Pi	Part II. Dther significant conditions cor	tributing to death but not re-	sufting in the u	ınderlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
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	Completed						24a. Was autop			opsy findings availat
	Con						perfor 1 ☐ Yes	med?	death?	2□ No
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	ို	T Yes 2 X No		ER/Outpatie	III 3 DOA		ome 5 🗆 Resid			ify)
	ertification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe h	ow injury	occurred	
	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, st		,163 2 0140	28f. Location (S	treet and	Number or Rur	al Route Number,
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	edical C		sician: To the best of my kn ner: On the basis of examinand manner stated.							
	¥ E	29b. Signature and title of certifier			29c. Licen			29d. Date	signed (Month,	Day, Year)
		1 (buleron	m.D.		Do	058392		June	= 24,	2005
		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	Print)		1			
A		50. Harris and address of person who oc	Am los Pac 32. Registrar's Sign							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Rag. NZ U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month June **Physician** 2005 Charles Vincent Harvey, Jr. 2:43 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 24 Hrs. 8. Date 418 Thayer Ave. Montgomery 8. Date of Birth Sep. 10, 1931 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Wash., DC 5. Social Security Number **Funeral** Days 1 □XM 2 □ F 73 577-42-2958 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23a or 28e-1 show eny injury or other treumatic event, the Medical Examine. 10c. City, Town or Location 10d. Inside City Limits 10b. Counts 1 TyYes 2 □ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 Thayer Avenue 20910-5316 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electric Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Charles Vincent Harvey, Sr. Louise Boston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 418 Thayer Ave., Silver Spring, MD 20910-5316 Barbara J. Harvey - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Quantico National Cem. 6/24/2005 Triangle, VA 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 23a. Part. Phier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for u Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by resolerant Cardiovascul 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No Derinheral Vascular 1 Yes To the Hospitel or Attending Physiclen: within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide 1 - Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 423 Queenshung Rd Hyuttsville and 20187 31. Date filed (Month, Day, Year) State Registrar JUN 2 4 2005

			For State Registrar	State	of Mar	yland / I		rtment				lental Hy	giene Reg. No?	005	229	512
	Dhusisi		1. Decedent's Name (First, Middle, Last									2. Date of De		and Par	3. Time	of Death
ı	Physicia /Medic		Catherine Deans									June	20 ^{Day}	2005 ^{ar}	5:05	P. M
	Examin	er	4a. Facility Name (If not institution, give		ımber)			_		Location	of Death		1	County of Dear		
-			4203 73rd Avenu 5. Social Security Number 6. Se		7. Age (In yrs. last bi	irthday)	If Under		If Under	24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State	or Foreian
	Funeral Director			M 244	57	'In yrs. last bi	Yrs.	Months	Days	Hours	Min.	(Month, Da 12/22/	y, Year)	Co	son Co.	
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	the N	Directo	Md. P.G. 10e. Street and Number				Lar	10f. Zip				1	10g. Citiz	en of What Co	ountry?	
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	filed within 72 hours after deeth with the Maryland Hygiene. ther than "naturel", or Items 23a or 28e-f show int, the Maulical Examinat counts or notified at	Funerai	11. Marital Status	12. Was Dec	cedent Eve	er in U.S.	13. V	Vas Deced	ent of Hi	spanic Or n. Mexica	igin? (Spe	ecify Yes or No Rican, etc.))- 1	4. Race - Ame Black, Whit		
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Box 6	leath certifica attending ph I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o				-					2	3d. Date of de	livery	
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ta		a)	25. Was case referred to medical							26. Plac	e of Deatl	1 Yes	2 No one)	I L Yes	2 □ No	
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(JU (5)		30. Name and address of person who o			•							2077	74		
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				State of Maryland		rtment of H								
				Registrar 1. Decedent's Name (First, Middle, Last)		incate of i	Jean	2. Date of Dea	th 200	5 23/	rime of Death			
_		Physici		Larry Holland				JUNE	18 at	Year 6	5:25 PM			
		/Medic Examir		4a. Facility Name (If not institution, give street and number) Doctors Community Hospital		4b. City, Town, or Lan			4c. County o	of Death e Geol	rge's			
	Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. II) $214-50-9406$ 1 M $2\Box$ F	last birthday) _ 55 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. Mar I Pay	1°9′50	9. Birthplace (Mary 1. a	(State or Foreign and			
		D .		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Loc	eation				10d Jr	nside City Limits			
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		the N	Funeral Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of Wi	hat Country?				
pa		3a or	i D	1077 Largo Rd.		20774			USA					
diland		deatl	ner	Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. W	Vas Decedent of H	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- American Inc., White, etc.	dian,			
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	Maryland 21215-003	nd 2 sho lith and I 27 is me r traums		19a. Informant's Name/Relationship (<i>Type, Print</i>) Doris Gray (Mother)	E	g Address (Street a		Rural Route Number and Rd.						
ary	altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exams at must be notified at once.			Place of Disposement of Cemete	sition (Name of paterylater) erv	e) 6-		20c. Location - C Lothian	-	itate			
7	Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401										
	8760,	rate be executed /Medical Examiner /Medical and // // // // // // // // // // // // /	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart farfure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the cond	uence of): 4 1 0 uence of):	Lung	Com	con N	en - Sm	Inter	et and Delath			
	P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day	Year			
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		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno (2 Medicel Exeminer: On the basis of examina and manner stated.										
		To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens		_ \	29d. Date signed	(Month, Day,	Year)			
				> X from Com Hode	5/101		200	101	6150	102				
				30. Name and address of person who completed cause of death (Item Mukemil Abdella 600	5 La	ndover	Rd., S	te. 3, C	heverly	MD	20'785			
		St. Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signa	iture	6.0.				•				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Gloria Jeanne Hudson 2:0% /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** al Vicomic a - Kegyond eninsula bun If Under 1 Year | If Under 24 Mrs. Date of Birth (Month, Day, Year) Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday, 6.\Sex 5. Social Security Number **Funeral** Hours Month's Days 1 □ M 2 13 F 59 222-28-4855 9-27-1945 Director Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Delaware Frankford Sussex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 19945 United States RT# 4 Box 113-K 23a Funeral 14. Race - American Indian, Black, White, etc. Items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 No Specify: Specify þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 ts marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) Cabinetry Bookkeeper Department of Health and Mental Hy, Important: If Item 27 is marked any injury or or. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roxie Wilkerson Edward Tingle 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 34799 Wilgus Cemetery Rd., Frankford, DE., 19945 Jerald W. Hudson, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3 □Removal from State 1 ☑ Burial 2 ☐ Cremation 6-23-2005 Roxana Cemetery Roxana, Delaware '4 □Donation 5 □ Sther (Specify) ^{22. Name and Address of Facility}
Melson Funeral Services Ltd.
Thatcher St., Frankford, DE. 21. Signature of Funeral, Se Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due 6 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examine the attending physician and hed for use as the burial-transit certificate be executed Due to Division of Vital Records, P.O. Box 68760 Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Tes 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th 27. Manner of Death 1 Natural 1 🗌 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide vo the Hc.
within 24 hours.
To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 0 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 100 SIMONA 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Day 19 Elliott B. Johns June 3:36 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. June 27, 1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 √ M 2 □ F Yrs. 092-01-1020 91 West Indies Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director New York New York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 E. 95th St. 10128 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked othar than $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\,\text{th} \end{array}$ College (1-4or 5+) Building Services Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rollock Eunice Johns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yvonne Johns - Daughter 2809 Denley Pl., Silver Spring, MD 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or otl
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Mount Cemetery 6/25/2005 Staten Island, NY 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home 21. Signature If Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Pneumonia</u> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Severe Dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Renal Failure 24a. Was an autopsy performed certificate 2**X** No 1 Yes 2 No Dementia Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No After this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D60826 June 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20910 Kshama Garg, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Month Year **Physician** George King, I 2005 lune /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Wicomico Peninsula Regional Medical Center SA/ISBURY Boate of Birth (Month, Day, Apr. 2, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Deys Hours 1 X M 2 □ F 67 Yrs. 1938 Maryland 577-50-7448 Director Apr. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23s or 28s-f shorement to the result of states of the Delmar DE Sussex 1 ☐ Yes 2 K No Funeral Director 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? 19940 United States 34515 Stanley Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. Armed Forces. 1 No 1 Yes, Give 158-68 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify. White Completed by 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Mechanic Auto/Airplane G.E.D permit. Peges 1 and 2 should be file Department of Health end Mentel Hy, Important: if them 27 is marked other any Injury or other traumatic event, DINCE. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leona Mae Cassidy George Leonard King 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 34515 Stanley Way, Delmar, DE 19940 Lora L. Young/Companion 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Shore Veterans Cemetery 07/01/05 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $Framptom\ Funeral\ Home$, P.A 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Coronary for usa as the bunal-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Voe

Hospital or Attending Physician: The law raquiras that the death certificate be executed Be P this Director: After this in by the funeral d Certification: death. **Director**:

55# 577-50-744

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Hospital:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

SALISBURY MD

29b. Signature and title of certifier

1 npatient

Date of Injury (Month, Dey Year)

29c. License number D54807

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Yeer) 6-28-2005

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

R. AgorNAI, M.D 31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Yes 2 No

27. Menner of Death

1 Naturel

2 Accident

3 🗀 Suicide

32. Registrer's Signeture

100 E. CATROIL

5 Pending investigation



24 hours a

within 24 hor To the Fune completely fi

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State Registrar

2 ER/Outpatient 3 DOA

28b. Time of Injury

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. N/2. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:15 2005 Keller June Andrew /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles 2335 Woodberry Drive Bryans Road If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Oate of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 € M 2 F 57 216-50-8980 20, 1947 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow traumatic avant, the Medical Exarchian must be notified at 1 ☐ Yes 21 No Directo Bryans Road Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. or itams 23a 20616 2335 Woodberry Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or than any injury or other traumate. 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify 3 Widowed 4 Divorced White 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Baker ဂ Clell H. Keller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2335 Woodberry Dr. Bryans Road, MD 20616 Elizabeth J. Keller/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Colesville Cemetery 06/24/2005 Silver Spring, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head darfure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition - UN7 Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Iner The law requires that the death certificate be executed the attending physicien and ched for use as the burial-transit Exam resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes To the Hospitel or Attending Physician: within 24 hours atter death. ↓o the Funerel Director: After this certitics Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 20 No 1 🗌 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier (5) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** June 19 2005 3:40 A Richard Joseph Koll, Sr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Year) Days **Funeral** 1**∑**M 2□F Hours 60 06/23/1944 New York Director 225-60-6736 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State worle r 28a-f ehov 1 TYPS 2 No **Brookeville** Directo Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ral", or items 23a or Examiner must be United States 19416 Brookeville Lakes Court 20833 death , Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2X No Yes, Give filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Chief Financial Officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Helen Mollman Victor Koll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19416 Brookeville Lakes Court Brookeville, MD 20833 Lucy Koll - Wife of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 06/22/2005 Sharps, VA 4 ☐ Donation 5 ☐ Other (Specify) Milden Cemetery 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc 21. Signature of Funeral Service Licensee Myslin, blobert 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed nding physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Renal Cell Carcinoma 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X No 1 Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 1 ☐ Yes 2 X No S 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 27. Manner of Death Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Director: 6 Could not be 3 Suicide determined filled in by 4 Homicide after 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 06/22/2005 D 56187 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 15225 Shady Grove Road, Rockville, MD 20850 Roberto Pedraza,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 4 2005

			For State Registrar	State	of Maryl	and / Dep	artmer			and M	_	giene Reg. N	Ane	22510
	¥		Registrar Decedent's Name (First, Middle)	, Last)			Timoat	001	Joann		2. Date of De.	ath		3. Time of Death
F	Physici Medic		Colenda I	· Karn	is						June 1	8, ^{Day} 20	05 Year	10:00 A M
	Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location o	of Death			ounty of Death	
8			43 Ridge Ave.	- 0	1		_	dgewa	ter ff Under	24 Hen	0.0		ne Arur	
	uneral irector		5. Social Security Number 406–26–0723	6. Sex 1 ☐ M 2 💢 F		yrs. last birthda Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da 10-7-1	n y, Year) 914	9. Birth	place (State or Foreign intry)
land	Mc #		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or	ocation							10d. Inside City Limits
Mary	a-f sh iffed	tor	Maryland Anne	Arundel		Edgew	ater							1 ☐ Yes 2 X No
ith the	or 28;	Directo	10e. Street and Number				10f. Zip						en of What Cou	intry?
ath w	8 23a		43 Ridge Ave.	40.11/- 5		:- 11.0		21037		-:-0 (0	- Y V N-		USA 4. Race - Amer	inna taolina
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	marked other than "natural", or liems 23a or 28a-f show matic event, the Madical Examinar, wat be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 ♥ Widowed 4 □ Divorced	ied 1 TYe	ecedent Ever Forces? es 2 No Give r Dates:	in U.S.	If Yes, spe		n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, White	
5-0	natur	eted	15. Deceden (Specify only highes	t's Education	od)	16a. Dec	edent's Usu re kind of wo DO NOT u	af Occupa	ation during mos	t of worki	ing	16b. Kind	d of Business/li	ndustry
21215-0036 d within 72 hours af giene.	han e Max	Completed by	Elementary/Secondary (0-12) 12th	1	e (1-4or 5+)		ם מסאסדים rtist	se retired)				Art	
filed N	other ant, II	e Co	17. Father's Name (First, Middle,	Last)	***************************************		TCTSC		18. Mothe	er's Name	(First, Middle,	Maiden S		
arylano should be	rked c	To Be	Henry Singleton	1					Moyn	a St	imson			
Maryland of 2 should be file the and Mental Hy	Importent: If item 27 is marked any injury or other traumatic at <u>once.</u>	•	19a. Informant's Name/Relations	hip (Type, Print)			•	,			al Route Numbe			p Code)
e, P	am 27 ther t		John J. Karpis/ 20a. Method of Disposition	Brother	20	b. Place of Dis	position (Na.	me of			ter, MD		37 ation - City or T	own. State
ages nt of h	t: If it		1 ☐ Burial 2 【** Cremation `4 ☐ Donation 5 ☐ Other (S		om State	cemetery, cr Kalas C	ematory or o	other plac		6–21.			water,	
altimore,	orten injur		21. Signature of Foneral Segret			ratas C	22. Name a	or Addres						ral Home
	d w od		Montoll	lele_			2973	Solon	nons :	Isla	nd Rd.	Edgew	ater, 1	ID 21037
	sician edical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	in each line.	fointe						rrest,		Approximate Interval Between Onset and Death
Exa	ıminer		Sequentiafy list conditions	b										
p	sit	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due	to (or as a cor	nsequence of):								
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	ng ph) as th	-	fF FEMALE:	_										
O. Box 68 the death certifica	by the attending phy tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1⊡Liv 4□Pr	outcome of prove birth 2 egnant at time aknown	Fetal death 3	□Ectopic p □ Other (s)					23	3d. Date of deliving Month	rery Day Year
S, P	gned se de	by Pl	Part II. Other significant condition	_		-		cause give	ən in Part I	*				the cause of death?
ord	been sig		Congest.	ive h	KanT	tailur	e				10	Yes 2 🗆		bably 4 Unknown
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D To the Hospital o	To the Funeral I	Medical Co		ng Physicien: To Examiner: On the										
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			30. Name and address of person	1/100	ause of death	(Item 23a) (Typ	e, Print)	-1/-	11 0	1	Boure	inco	207	6
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JOSEPH CHARLES LEE June 19. 2005 1:57A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner LaPlata
or 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Charles Civista Medical Center If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**☐M 2☐F 79 MAY 28, 1926 MARYLAND 219-16-0150 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "naturel", or Items 23e or 28e-f show traumatic event, the Medical Examinations to notified at 1 ☐ Yes 2**X**☐ No MD CHARLES PORT TOBACCO Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7500 PORT TOBACCO ROAD 20677 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1845 1 TYYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Joseph Lee Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) parmit. Pages 1 and 2 should ba filed will Department of Health and Mental Hygiene Importent: if item 27 is marked other the eny injury or other traumatic event, Ital QDICe. CARPENTER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH LEE MARY CATHERINE JENNIFER LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANNA LEE/WIFE P.O. BOX 265, PORT TOBACCO, MARYLAND 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ST. CATHERINE CHURCH CEM JUNE 25, 2005 MCCONCHIE, MARYLAND 21. Sa sture of Fundral S. rvice in 12.0 22. Name and Address of Facility THORNTON FUNERAL HOME, P. A 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LYDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death VASCULAR Immediate Cause (Final CEREBRO -Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury burial-transit certificate be exacuted that initiated events and resulting in death) Last Due to (or as a consequence of): nding physician Records, P.O. Box 68760 Physician/Medical usa as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 MYOCARDIAL INFARC 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No TENSION PER 1 ☐ Yes 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a
To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of chrtifier 29c. License number 6-19-2005 D-26064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vidyasagar Anmangandla, MD Rt 5 & Golden Beach Rd Charlotte Hall, MD 20622

State Registrar JUN 2 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. Np? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:30 A M June 18 2005 <u>Jeanette Padgett Mortzfeldt</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 229 Hannes Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 TO F Texas 08/27/1939 65 Director 455-60-2493 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28e-f show other treumatic event, the Medical Exertine round be notified at 1 Yes 2 No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20901 238 229 Hannes Street Funeral death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? items; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No filed within 72 hours after 1 ☐ Never Married 2 X Married 5 Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. If Yes, Give ρ 3 Widowed 4 Divorced Year or Dates: nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7/2 Department of Health and Mental Hygiene Importent: If item 27 is marked other then "ns eny injury or other treumatic event, The Medisons. Elementary/Secondary (0-12) College (1-4or 5+) Federal Aviation Cartographer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Neistroy Garnett Padgett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3502 Fullerton St Beltsville, MD 20705 Ronald Mortzfeldt - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【** Cremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 06/23/2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave Silver Spring, MD 20904 Myelin T. Wobert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Inutes Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 2 No To the Hospitel or Attending Physician: direc or, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner's Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the hours after deat 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and title of cer-06/21/2005 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Ave 2nd Floor Kensington, MD 20895 Barry Rosenbaum, MD State JUN 2 4 2005 Registrar

		í	1 - State of Maryland / Department of Maryland	rtment of Health and N tificate of Death			05	22522
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Richard G. McKinnon		2. Date of Deat Month June	Day 23	Year 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			nty of Death	
	Funeral		Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Berlin If Under 1 Year If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign
	Director		141-14-2050 1 [™] 2□ F 82 Yrs.	Months Days Hours Min.	Nov.17,	1922	New	Jersey
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation				10d. Inside City Limits
	e Man Ba-f sh Lifted	ctor	MD Worcester Ocean F	Pines				1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number	10f. Zip Code		og. Citizen d	f What Cou	ntry?
	death	Funeral	22 Stacy Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Vanded Forces?	21811 Vas Decedent of Hispanic Origin? (Spirys, specify Cuban, Mexican, Puerto			ace - Ameri	
36	s after , or ita	by Fui	1 Never Married 2 X Married 1 X es 2 No If Yes Give WWII	Yes 2 No Specify:	nican, etc.)	Spec	lack, White, cify: Wh	etc. nite
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d 21	filed w Hygiei othar tl		12 Ow 17. Father's Name (First, Middle, Last)	ner 18. Mother's Nam	e (First, Middle, A			ompany
/lan	uld be Mental Irkad c	To Be	Unknown	Unkno	wn			
Maryland 21215-0036	12 sho h and l is ma rauma			g Address (Street and Number or Rui		D-53-5455 S		Code)
ē,	Healt Healt tem 2		20a Method of Disposition 20b. Place of Dispo	tacy Court, Oceai		Md. 20c. Location		own, State
altimore,	Pages nent of ant: if i		4 Donation 5 Other (Specify)	of the Pines 6-2	27-05	Ocean	Pines	,Md.
Balti	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is markad othar than "naturel", or itams 23a or 28a-1 show any injury or othar traumatic event, the Medical Examinat must be notified at once.			Name and Address of Facility The William St., Ber			neral	Home
			23a, Bert I. Enter the tissease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
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Mck H Division	l or Attan after deatl Diractor:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	eet and Nun , State)	nber or Rura	al Route Number,
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	To th To th compl	Me	29b. Signature and title of certifier	29c. License number	29	d. Date sign	ned (Month,	Day, Year)
			C feffer Matrie No	HU053714		61	23/0	5
8	T 10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Leftery Matzoni 314 Franklin	Print) Ave Suite 302	Bentin	mo 2	1811	
	Sta	4.	24 Date filed (Afresth Cov. Vene) 20 Desistrario Cinneture				· × . i . j	
	Registr	ar	JUN 2. 4 2005					t-

		State of Maryland / Department of Health 1- State Registrar Certificate of Death	and Mo	ental Hyg	iene	005	22523
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/Medi Examir		Roy Aloysius Mead 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location	n of Death	0		ounty of Death	
LAdiiii	101	30 Capetown Rd. Berlin			W	orceste	r
Funeral Director		5. Social Security Number 189-26-1939 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. Birth Con Pitt	plece (State or Foreign intry) ston, PA
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all y la	ို			salie K			in Codo)
S 8 8 9		19a. Informant's Name/Relationship (Type, Print) Suzanne T. Mead/ Wife 19b. Mailing Address (Street and Numb 30 Capetown Rd.,					p Code)
of Health ritem 27		20a. Method of Disposition 20b. Place of Disposition (Name of				ation - City or 1	own, State
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		The state of the s				011	Approximate
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The could us, F.C. BOX 00 (00), The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23	d. Date of deli Month	very Day Year
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nysici nis cer	To B	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N	Nursing Hom	ne 5 Reside	ence 6 []Other (Spec	ify)
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To the Hospital or Atten Within 24 hours after deat To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, de and manner stated.					
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- > - 0		Laure Oraace D1425	56		6	122/04	\$
1/41		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	51 D	EERH	75/17	Hos	5 52/80/
I, GTI Sta	até	THMES W. (GAACS THOSTICE 72 31. Date filed (Month, Day, Year), 32. Segistrar's Signature	047	Sote 19	134	14	> 2/80/
Regist		31. Date filed (Month, Pay, Year) 32. Fegistrar's Signature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:00 P M 2005 Mae Newman 15 Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cheverly Prince Georges Hospital Center
5. Social Security Number Da. Sex 7. Age (In yrs. last birthday) Prince George If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □xF Days 578-50-4899 Yrs. 68 25, Wash., DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Show r than "natural", or Items 23a or 28a-f shov the Madical Examinar must be notified at 1 XYes 2 □ No Director Prince George's Maryland Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5719 Bugler St. 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White fiscan should be filed within 72 hours after and Mental Hygiene. marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: American þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygier
Important: if Item 27 is marked other 1t
any injury or other traumatic event, IIIs
Once. 7th Homemaker Self-Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Secret Williams Eugenia Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6200 Edward Rd., Clinton, MD James R. Newman, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 6/22/05 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Wal 23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Disease Physician Arter a Covonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Deat Brain Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2XNo 3 Probably 4 □Unknown pertension, Chronic obstructive Pulmonan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Disease, autopsy performed? Yes No 1 ☐ Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the 29c. License number D550220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hosp DR Cheverly Mp 20785. Matin MD Terri 3001 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 **Physician** 7:00 AM June 19, MARY ELLA LEWIS NUTTALL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard County Clarksville HILLSIDE HOME ASSISTANT LIVING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 31 1914 9. Birthplace (State or Fo 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2**X** F Yrs 90 <u>578-34-7</u>768 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r then "neturel", or items 23a or 28a-f show the Medical Examinar must be notified at Yes 2 □ No Director Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21044 death Funeral 5412 Bucksaw Court or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** Be Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government +01 Secretary 12th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Isaac Lewis Esther Timberlake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5412 Bucksaw Court Columbia, Md. 21044 Helen Nuttall/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 6/24/05 Brentwood, Maryland 21. Signature of Funeral Service Licensee Frazier's Funeral Home, Inc. 389 RI Ave., N.W. Wash.,DC 20001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CRONARU 5 MEGNS Physician /Medical Due to (or as a consequent Examiner Sequentially list conditions, I any, leading to infine dide cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No ed by the 9 Unknown 9 □Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA P this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a

To the Funerel C

completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M-) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 2 2 2005 Registrar

			1 - For State Registrar	ate of Marylan	-	ertment o					005	2252	6
	Physic /Medi		1. Decedent's Name (First, Middle, Last) James Robert	Norris		·			2. Date of De Month JUNE		, 2005	3. Time of Dea 8:53A.	ath M
	Exami		4a. Facility Name (If not institution, give street CIVISTA MEDICAL CENT	ER		LA P	LATA			CHA	County of Death		
	Funeral Director		5. Social Security Number 217-32-0484 Usual Residence of Decedent	7. Age (In yrs. 175)	ast birthday) Yrs.	If Under 1 Y Months Da		Under 24 Hrs. Hours Min. Sep	(Month, Da	y, Year)	Cour	place (State or Fo ntry) aryland	_
	Maryland	tor	10a. State 10b. County Charles		y, Town or Lo	cation Island	1				1	0d. Inside City L 1 ☐ Yes 2	
	or 28	Director	10e. Street and Number			10f. Zip Co	de			10g. Citiz	en of What Cour	ntry?	
	sath w	rai	12122 Neale Sour		e 12 1		0625		acify Vac or No	. 1.	USA 4. Race - Americ	an Indian	
920	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show ofical Examinations to Interest	by Funeral	1X Never Married 2 Married 1	/as Decedent Ever in U. med Forces? ☐ Yes 為 No Yes, Give ear or Dates:		Yas Decedent f Yes, specify		nic Origin? (Sp lexican, Puerto pecify:	Rican, etc.)		Black, White,	etc.	
2-0	72 hou	eted	15. Decedent's Education (Specify only highest grade con	n npleted)	(Give	lent's Usual O	one durin	n ng most of work	ing	16b. Kin	d of Business/In	dustry	
Maryland 21215-0036	be filed within 7. Ital Hygiene. Id other than "n	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	life. I	ore C)wne	r		Advisor C	Retai	1	
yland		To Be	17. Father's Name (First, Middle, Last) Andrew James Norr				L	. Mother's Name illian	Irene	e Fa	rrell		
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, F A.J. Perk/brother			•		Number or Rura White			Town, State, Zip D 2069		
	s 1 and 2 if Health item 27 i		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name o	of		Date		ation - City or To		
<u>im</u>	o o		1 XBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	/at from State	y Gho	st Ce	met	ery 6/	25/05	Iss	sue,Mar	cyland	
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee	hal MOOS	945 22	AREHA	ddress of RT -	ECHOLS	FUNER	RAL I	HOME, P	A. Approximate	
П			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death use on each line.	n. Do not ent	er the mode of	dying, s	uch as cardiac	or respiratory ai	rrest,	20,	Approximate Interval Betweek Onset and Deat	n ih
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a contegu	Tence of).	Xuu	es	-					
	Examiner		Sequentially list conditions b. —	Bac (6) (6) ac a con c oq)							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):								
Ć,	tate be executed by siclan and the burial-transit	Examine	that initiated events c	Due to (or as a consequ	uence of):								
8760,	ate be nysicla he bur	dicai	d										
.O. Box 68	death certific e attending p d for use as	Physician/Mec	in the past 12 months?	yes, outcome of pregna □Live birth 2□Fetal □Pregnant at time of de □Unknown	death 3	Ectopic pregn		_		23	3d. Date of delive	ery Day Year	
s, P	Se Ba	by	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the ur	nderlying cause	e given ir	Part I.	23e. Did to	-		ne cause of death	
Record	e law has b	ompleted							24a. Was autop perfo		prior to con death?	psy findings avai πpletion of cause 2□ No	able of
of Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					. Place of Deat					
of \	this al dir	၉	1 Yes 2 No Hospit	al: 1 □ Inpatient 2 □X a. Date of Injury	R/Outpatien				me 5 Residence 128d. Describe		Other (Specification)	y)	
	ing After une	ation:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	7:45		Injury at Work? 1 ∐ Yes		Decoused		ia car	struck	_
Division	in Direction	Certificati	3 Suicide 6 Could not be determined 28	e. Place of Injury - At ho building, etc. (Specify	me, farm, str		fice		28f. Location (S City or Tow	Street and vn, State)	Number or Rura	Route Number.	110
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	-62	29a. Certifier 1 ☐ Certifying Physician (Check only 2 Medical Examiner: €	1: To the best of my known the basis of examinat				date and place,		cause(s) a	and manner as s		MI
	To the within 2 To the comple	Medic	29b. Signature and title of certifier	and manner stated.			cense nu			29d. Date	signed (Month,	Day, Year)	
	F > F 0		MANA	X /VI		(OCME			JUNI	E 21, 20	005	
1	B 18		30. Name and address of person who comple	AN		111	Penn	Street	Balti	more,	, Maryla	nd 21201	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 2 2005	32. Redistrar's Signar	J. A	park							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 11, 2005 3:36 A.M. LOUISE OWENS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 10/9/22 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 82 Yrs. Director 578-88-9019 Washington, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rel, or items 23a or 28a-f show Examiner roust be notified at Maryland Montgomery N☐Yes 2☐No Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9109 Second Avenue 20910 U.S.A. perriit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23a any injury or other treumatic event, the Medical Examination 2006s. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 'n none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Lawrence Owens unk Farr 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 429 O Street N.W. 19a. Informant's Name/Relationship (Type, Print) case Larissa R. Crossen/ manager Washington, D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 06-21-2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Adelphi, Maryland George Washington Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th St., N.W. Wash., D.C. 20010 Vanda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 12hrs neamonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner to Sunlowing disorder Aspiration Secondary Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury Examiner nec i dent requires that the death certificate be executed Cerchini Vascular and resulting in death) Last Due to (or as a consequence of): physician ar Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown o. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by letural ntien ougenital 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ○ Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 일 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/11/2005 12elter MD 25586 Jaugh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Celumbia Road, no suite 334 Washington, DC 20009 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 2 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrer Reg. No. 2005-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 Dorathy N. Onyeukwu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Doctors Community Hospital Lanham If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Owerri 5. Social Security Number **Funeral** Min. Hours Months 1 M 200 230-95-7118 34 Nigería Director June 20, 1970 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and telms 23s or 28s-1 show ant: if item 27 is marked other than "natural", or items 23s or 28s-1 show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exal then must be notified at 1 XYes 2 □No Director Prince George Lanham 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6303 Rory Ct 20706 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice Onveukwu Justina Duru 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health at Important: if item 27 is any injury or other trauonce. 6303 Rory Ct Lanham, MD 20706 Victoria Nwosu/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Family Plot 7/16/05 Obazu, Nigeria J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 Landover Road Landover, Maryland 20785 23a. Fart: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiph **Physician** Advanced unknow. disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Roint Frank 1243446 6.17.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave suit 3-41 Silva SPring MD 20902 FARAHIFAR MD ROINTAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 2 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5:45PM 2005 Alvin Irvin Orlowek June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Village Health Care Center Montgomery Village If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**☑** M 2□ F 82 Chattanooga, Director May 126-14-2403 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1√ Yes 2 No Directo Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 837 Loxford Terrace United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene.
ant: If Itam 27 Is marked other then "natural", or Ital.
ary or other traumetic event, the Medical Examination. 1 ☐ Yes 2 ☐ No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ Year or Dates: WWII 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Federal Government Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Nathan Orlowek Fanny Besser ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nathaniel Orlowek, Son 7855 Coddle Harbor Lane, Potomac, MD Important: If Itam any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 06-24-2005 Adelphi, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave Silver Spring MD 20904 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to lor as a consuluence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes cate has been sly , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes XXNo 2 X No 1□ Yes tha Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c Certification: After 5 Pending after death.

I Director: Aff 1 🗌 Yes investigation 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funeral C completely filled i 29a. Certifier fig. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month. Day. Year 29c. License number 29b. Signature and title of certifier D41102 June 23, 2005 NN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, M.D. 19529 Doctors Drive Germantown, MD 31. Date filed (Month, Day, Year) State Registrar JUN 2 4 2005

			1 - State Amend Item 2	State of per ME	Maryland	d / Depa 7/08/ (artment of	Health an	d Mental H	ygiene	0.5		
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	/Medic Examin	-4	4a. Facility Name (If not institution, g	ive street and nun	nber)		4b. City, Town,	or Location of E			ty of Death	i	-
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Maryland 21215-0036	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree	!	or Rural Route Num		n, State, Zi	ip Code)	
	nd 2 salth ar		Glenn K. Parr/						race, Coc	•			273
J.	ss 1 a of Hez item		20a. Method of Disposition		1 00	ace of Dispo	sition (Name of natory or other pi	lace)	Date June 21.	20c. Location	- City or T	own, State	
ii.	Page nent c ant: If		1 ♣ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec				even Cemet		2005	Silver	Spri	ng,Mar	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. importent: if item 27 is marked other then "neturel", or items 23a or 28e-f ehov any injury or other treumatic event, the Medical Examinal must be notified at once.		21. Signature of Funeral Service Lio	(Soul	L-				ns Funera lvd, W, S			,MD 20	0901
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			1 - State of Maryland / Department of Head Certificate of Dea		R	20 ()5	22531
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James Polite		Date of Deal Month June	Day	Year 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat	tion of Death	-	4c. County	of Death	
			Doctors Community Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	nder 24 Hrs. 8	1001	Princ		
	Funeral Director		247-58-0100 1™ 2□F 64 Yrs. Months Days Hou	urs Min.	Date of Birth (Month, Day, 2/28/19			place (State or Foreigr ntry) n Carolina
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	10d. Inside City Limits
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	th with	alD	600 Ivy Leaf Avenue 20743		τ	U.S.A.		
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatith and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No II ☐ Yes 2 ☒ No II ☐ Yes Give 1 ☐ Yes 2 ☒ No	c Origin? (Specifixican, Puerto Ric	fy Yes or No- can, etc.)		ce - Americ ck, White, y: B1ac	
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ary	and Maland Maland		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No.			-		
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Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dat		20c. Location		
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Bal	Depar Impor any ir		21. Signature of Funeral Service Licensee 22. Name and Address of F					ie .
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68760,	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
P.O. Box (w requires that the death certif been signed by the attending should be detached for use a	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify)			1	ate of delive	ery Day Year
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Division of Vital Records,	ttending Ph death. stor: After th t the funeral	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 28c. Injury at Work? 1 Yes		d. Describe ho	ow injury occur	red	
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Z	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Check only one one of the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, and , death occurred	d due to the call at the time, d	ause(s) and ma date and place,	anner as s and due to	stated. o the cause(s)
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	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	RAZII	lei n	w	20	737
			21 Date Slad (Morth Day Year) 22 Beginners Signature					

ORIGINAL

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1 Decedent's Name (First, Middle, Last) 2005 Year **Physician** June 20. Richard J. Parisi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bowie

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Jan. 29,1936 Prince Georges Bowie Health Center 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. 091-28-1307 69 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 77 is marked other then "naturel", or Items 23s or 28s-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2408 Kelford Lane 20715 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permil. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or Iten any injury or other treumatic event, I're Madical Examinat. once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Labor Relations Specialist U.S. Govt. 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Parisi Esther Diodati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Parisi / Spouse 2408 Kelford Lane Bowie, MD. 20715 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resurrection Cemetery 06/27/2005 Clinton, MD. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. Bowie, MD. ac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction 2 hrs. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 years Diabetes Type II Sequentially list conditions, if any, leading to immediate eause. Enter the denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ⊠No 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 ☑ No 1 Inpatient 2 R/Outpatient 3∏ DOA his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Dobin, M.D.4175 N. Hanson Court Suite 203A Bowie, MD. 20716 31. Date filed (Month, Day, Year) . Registrar's Signature JUN 2 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician JANE LAW PEDERSEN June 17 2005 10:35 P^M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year Oct. 22, 19 **Funeral** Days Hours 1 □ M 2 🖾 F 53 1951 California Director 212.54.4797 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show r than "natural", or Items 23a or 28a-f shov The Medical Exarirer must be notified at 1 XYes 2 □ No Poolesville Montgomery Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19804 Spurrier Avenue 20837 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Institute of other than " College (1-4or 5+) 5+ Years Elementary/Secondary (0-12) Mental Health Microbiologist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be filt ont of Health and Mental Hy t: If item 27 is marked oth y or other traumatic eventy Be Melvin J. Law Beulah M. Enfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19804 Spurrier Avenue, Poolesville, MD 20837 Poul M. Pedersen/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
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Important: If itel
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 6/30/2005 Brentwood, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licersee 11800 New Hampshire Ave, Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart affilire. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MUCCARDIAL Physician MINGTES /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2 No 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

DHMH 17 Rev 1/2001

Box 68760

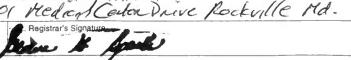
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Records,

Division of Vital

State Registrar

31. Date filed (Month, Day, Year) JUN 2 4 2005



rson who completed cause of death (Item 23a) (Type, Print)

AVID SROUN

## Parties Name (First Assistance, Now were and number) Comessis El ColorCarre Col			Tage State Registrar	otato or maryto	Ce	rtificate of De			g. No.	0 22034		
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25. Was case referred to medical examiner? 1	The la	mo							performed? death?			
29a. Certifier (Check only one) 29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print) 29c. Injury at Work? M 1 Yes 2 No 28d. Describe now injury at Work? M 1 Yes 2 No 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	sien: artifica ctor, p	a			Place of Death							
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			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H	ealth and Death	l Mental Hyg	lierre 005	22535	
I	Physici /Medic		1. Decedent's Name (First, Middle, La ${ m Eldon}$	st) Pusey				2. Date of Dear Month		3. Time of Death	
	Examir		4a. Facility Name (If not institution, given the facility Name (If not institution, given the facility Name) A. Social Security Number 6.5	NOR.	ge (In yrs. last birthday)	4b. City, Town, or PRINC	Location of De	ANNE	4c. County of Dea	RSET	
	Funeral Director		214-30-8663 Usual Residence of Decedent	M M 2□ F	83 Yrs.	Months Days	Hours Mi			thplace (State or Foreign ountry) cyland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show emportent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Example motified at ODGs.	To Be Completed by Funeral Director	10a. State 10b. County MD Worcest 10e. Street and Number 1210 Market Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.e) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last, Eldon T. Pusey 19a. Informant's Name/Relationship (Maralyn Adkins/Ni 20a. Method of Disposition 12 Occupantion 3 County (Specify only highest gr.e)	12. Was Decedent Armed Forces? 10. Yes 2 1 11. Yes 2 1 11. Yes 3 1 11. Yes 4 1 11. Yes 6 1 11. Yes 7 1	No WWII 16a. Deced (Give life. U F1	e City 10f. Zip Code 21851 Nas Decedent of Hif Yes, specify Cuba I Yes 2 No Ient's Usual Occuppe kind of work done of DO NOT use retired or ist G Address (Street at Line Roas sition (Name of natory or other place)	spanic Origin? n, Mexican, Pue Specify: ation furing most of w 18. Mother's N Cleo Pu and Number or I d, Delm b)	(Specify Yes or No- ento Rican, etc.) Porking ame (First, Middle, I 1Sey Rural Route Number, 2ar, DE 1 Date	Specify: White 16b. Kind of Business/Industry Flower Shop Middle, Maiden Surname) Number, City or Town, State, Zip Code) E 19940 20c. Location - City or Town, State		
8760, Balt	Physician /Medical Examiner	dical Examiner	21. Ignature of Funeral Service Licer 23a. Part1. Enter the disease, or comshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. 1 any Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b.	100295 1	Name and Address inman Fun 1673 Some	s of Facility leral Ho	me enue Pri	ncess Anno		
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	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	Medicai	one)	and manner sta	rexamination and/or inv	estigation, in my op	inion, death occ	curred at the time, da	ite and place, and due	to the cause(s)	
	F X F S		Num			0 4°	7094	25	3/05 Bd. Date signed (Month	T. Day, Year)	
		11	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, F (415 S` ar's Signature	Print) DU15/UN	ST	5A215B	vry MD2	1804	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8	2005 32. A	ar's Signature	Lux					

Eldon Pusey

			State of Marylan 1- State Registrar		artment of H			iene	15 22536	
	Physici		1. Decedent's Name (First, Middle, Last) Pressley Robinson				2. Data of Death	and the same of th	3. Time of Death 3:00PM M	
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospita	al	4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 579-66-4335 6. Sex 1 ★ 2□ F 7. Age (In yrs. 56	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Oct. 18,	^{Year)} 948	9. Birthplace (State or Foreign Country) Wash., DC	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's	ty, Town or Lo		elphi			10d. Inside City Limits 1	
	with the	Director	10e. Street and Number 1801 Metzerott Road		10f. Zip Code	20783	10	0g. Citizen of W	hat Country?	
36	Id be filed within 72 hours after death with the Maryland ental Hygiene. Aed othygiene. Red other then "neturel", or items 23e or 28e-f show see other then "neturel", or items 23e or 28e-f show ite event, the Maddell Examination must be multilled at	by Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes, Give 1! Yes, Give 1! Yes, Give 1! Yes, Give 1! Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)	14. Race	- American Indian, , White, etc.	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of war)	king	16b. Kind of Bus	,	
		Be	12th 17. Father's Name (First, Middle, Last) Rudolph H. Robinson	<u> </u>	Housing		ne (First, Middle, A		vernment	
Maryland	2 should and Me ls mark	₽ C	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a			della		
Baltimore, 1	Pages 1 and 2 should nent of Health and Men int: If item 27 is marke iry or other treumatic		A D D and a War and a D D D D D D D D D D D D D D D D D D	Place of Dispo	010 Nevin osition (Name of matory or other place rematory	B)		20c. Location - C	D 20/44 City or Town, State	
Baltin	permit. Pa Departmen Importent: eny injury once.		21. Signature of Fund Service Licensee 22. Name and Address of Facility Stewart Funera 4001 Benning Rd., N.E. Wash.,							
	Physician // Medical Examiner physician in the prival representation of th	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):							
s, P.O. Box 68	or Attending Physicien: The law requires that the death certific tractor and reference of the state of the st	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnat 1	Ideath 3	Ectopic pregnancy Other (specify)	1 COAC	ullo,	23d. Date	o of delivery th Day Year	
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N	To Witl	M	30. Name and address of person who completed cause of death (Item	1	1000	(307 A110	- -	06/1	(Morth, Day, Year) S 2-005 M NOM PANAL M D 2041	
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Np. 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 June 4:00 Hazel H. Reynolds /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 1, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□M 2□F Wash., DC 79 Director 577-76-0176 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 le marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic evant, the Madical Examinar match multiportant once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Director Bowie Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20721 United States 512 Jennings Mill Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: **Black** Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lonnie Harris Alberta Barnes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12221 Concho Ct., Lusby, MD 20657 Karen Noel - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place rk 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/05 Maryland National Mem. Laurel, MD `4 ☐Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licens Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End stage Cardiomyopathy **Physician** math /Medical Examiner 10 years heart disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Tyes 2 No Month Day Year jo 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown 5 signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attanding 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06-17-05 52119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Chatrathi, M.D. Suile 302, 8100 Goodluck Rd, Lanham, MD 20706 JUN 2 2 2005 Registrar

			For State Registrar	State o	f Marylaı	nd / Depa <i>Cei</i>	artment of rtificate of	Health f <i>Death</i>	and Menta		ene 005	22538
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	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town		of Death		4c. County of Dea	ath
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П	Funeral Director		004-24-1583	1 XXX 2 □ F	77	Yrs.	Months Day			"1, Day 19	28	ountry) Maine
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	and 2 saith a n 27 is		Frederick Redmond /	Son		312	Brockton	Road Ox	on Hill, Ma	arylan	d 20745	
Baltimore,	Pages 1 and of He out: If item		20a. Method of Disposition 1 XXBurial 2 ☐ Cremation	3 Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other p	lace)	Date	20	c. Location - City or	Town, State
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0	At)		30. Name and address of person w	ho completed caus	e of death (Ite	m 23a) (Type,	Print)		TIONAL NA THESDA ME		MEDICAL C 89-5600	ENTER
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			30. Name and address of person who co		3a) (Type,	Print)	2d #3	00 Ann	apo lis	s, MD	214	14
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			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of H			giene	0.5	00510
			Decedent's Name (First, Middle, Las.	")				2. Date of De	ath 20	U5	3. Clime of Deals
П	Physici /Medic		Mark Lee Stevens	3				June	22, 200	Year 05	2:40 P M
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	Funeral		5. Social Security Number 6. Se	x 7.]M 2□F	Age (In yrs. last birthday C = Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	y, Year)	Cou	
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	/land		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
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Maryland 21215-0036			19a. Informant's Name/Relationship (7) Sean Mooney Stever			ing Address (Street a Spout Run					
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Baltimore,	Pages nent of int: If It		1 Burial 2 Toremation 3 :		10	matory or other place 1 Cremato)	e ²⁴ ,			
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	• Hospital or Attendi 24 hours after death. • Funerel Director: A etely filled in by the f	Medical	29a. Certifier 1 \(\bigcap \) Certifying Phy (Check only one) 2 \(\bigcap \) Medical Exem	iner: On the basi and manner	est of my knowledge, dea s of examination and/or in stated.	in occurred at the time nvestigation, in my op	ie, date and place, pinion, death occur	red at the time,	cause(s) and n date and place	nanner as s e, and due to	tated. the cause(s)
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~	rsP0) (K,V		wo	D3563	5		June 23	, 200	5
1	1		30. Name and address of pers in who c	ompleted cause	of death (Item 23a) (Type	Print)					
	66.		Joseph Kaplan M.D.			1 Road Ro	ckville,	MD 2085	55		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** HINER SCARBRO 2005 9:00 AM JUNE 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTREVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Month, Day, Year) 2220 4-H PARK ROAD QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2♥F Yrs. 232-42-5591 Director 80 APRIL 12, 1925 WEST VIRGINIA Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2220 4-H PARK ROAD 21617 USA filed within 72 hours after deeth by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Specify: USA 3 ☐ Widowed 4 ☐ Divorced "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked othe may injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) STEPHEN HAMILTON HINER ANNIE VAUGHAN MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 4-H PARK ROAD, CENTREVILLE, MD 21617 ROMIE L. SCARBRO / HUSBAND 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6-25-2005 STEVENSVILLE, MD * 4 ☐ Donetion 5 ☐ Other (Specify) CENTER, LLC 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximated Cause (Table). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheiners **Physician** dementia year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. its Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deeth 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypertension 1 Yes 2 No 3 Probably 4 Unknown rebro vascular 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2□ No 1 Yes 2 PNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) eral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) V0055127 Calaro MA Maryland 22/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Love Point Rd Suite 107 Margaret Malaro M.D. 31. Date filed (Month, Day, Year) JUN 2 32. Registrar's Signature State 2005 Ween St. Aparte Registrar

		For State Registreramend item 1. Decedent's Name (First, Middle, L	#28e pe	Marylan	id / Depa 845 99 0	artmen <i>yificat</i>	t of ⊢ e_ opf	lealth a Death	and M	lental Hy 2. Date of De	Reg. 10	005	2 2 5 1, 2 3. Time of beath
Physician /Medical Examiner	1	SHARON DOLO 4a. Facility Name (If not institution, g 4101 Branch Ro	ive street and nun			Ten	nple	r Location o	S	June 1	40	2005 County of Dear	
Funeral Director		5. Social Security Number 6. 067-46-7194 Usual Residence of Decedent	Sex 1-□ M 2X F	7. Age (In yrs. 51		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10–28	th ly, Year, 1–53	9. Bro	rthplace (State or Foreig country) Ooklyn, NY
the Maryland r28a-f show notified at	10101	10a. State 10b. County MD P.G. 10e. Street and Number			y, Town or Lo	10f. Zip	Code				10g. Ci	itizen of What C	10d. Inside City Limits ty Yes 2 □ No Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If then 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	y i dileiai D	3833 St. Barnabu 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For	2 ∑ No e		207 Was Deced If Yes, spec	ient of H	ispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, etc.)).	5A 14. Race - Am Black, Wh Specify:Bla	ite, etc.
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death certificate be executed e attending physician and d for use as the burial-transit clan/Medical Examiner	מו וי	23a. Raff. Enter the disease, or co- sociate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c.	or as a consequence or a consequence or a consequence or a consequence or a consequenc	quence of):	er the mod	s of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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The law requires the state has been signed page 2 should be completed by	2	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying c	ause giv	en in Part I.		1 🔲	Yes 2	No 3 P	to the cause of death? Probably 4 Unknown Butopsy findings available completion of cause of s 2 No
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate completely filled in by the funeral director, pag. Medical Certification: To Be Co.	2	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	28a. Date of (Month) ton be 28e. Place building		(y)	/3 ^M	8c. Injun Wor 1 🗀	er: 4 □ Nu y at k?	No		dence how inju i るん ら Street a	Struck / Sdruck / nd Number or R	ecity) Scene by CAT Rural Route Number, et Hills, MD
Hosp 4 hou Fune ely fil	במוכם		Physician: To the aminer: On the ba	best of my kno	wledge, deat					and due to the			
To the within 2 To the complet		29b. Signature and title of certifier 20	lla) o completed cause	Al!	n 23a) (Type,	Print)	OCME		11.00		Ju	ate signed (Mon ine 14,	2005
State		2 AB (U.) 31. Date filed (Month, Day, Year) JUN 2 2 200		A L/	ature		⊥ Pe	nn St	reet	Balt	imor	e, Mary	land 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 20 2005 Cecile Schifferes June 7:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Springbrook Adventist Nursing Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Yrs. Director 94 137-34-5458 10/16/1910 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at **Funeral Director** 1 XYes 2 No Essex Livingston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 92 Belmont Drive 07039 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White Specify: δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. New Jersey Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker Public Schools traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Samuel Shapiro Ida Swyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte A. Schifferes-Daughter 4600 Connecticut Ave NW #523 Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 5 ☐ Other (Specify) Beth Israel Cemetery | 06/23/2005 Woodbridge, NJ 21. Signature of Fineral Service Lipensee 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc × (6 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the caus Approximate Interval Between Onset and Death mmediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the à s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fraility, End Stage Renal Disease, Malnutrition 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension, Endovascular Infection, 24a. Was an has page 2 autopsy performed? certificate Recurrent Pneumonia, Dysphagia 1 Tyes 2 No 1 Yes 2**∑** No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ▼ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending. After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ To the Hospital c within 24 hours af To the Funeral DI 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lewaentunga D53367 06/21/2005 10 30. Name and address of verson who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, MD 10810 Darnestown Rd Suite-202 Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 2 4 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Division of Vital Records,

			For State Registrar		State of	f Marylar		artment					giene Reg. Nd	2000	225	لي لي
			Decedent's Name (First,	Middle, Las	t)				-			2. Date of De	ath		3. Time of	
	Physicia /Medic				Earl Wil	lliam Smi	th					Month IUNE	2.2	y Yea 2005	1	5 A ^M
}	Examin		4a. Facility Name (If not ins	titution, give	street and nu	mber)		4b. City,	Town, or	Location	of Death		4c.	. County of De	ath	
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	Funeral Director		5. Social Security Number 233–42–6513	6. Se	M 2□F	7. Age (In yrs. 76	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept. 26	n, Year) 1029	Wos	irthplace (State or Country) st Virginia	-
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	be filed within 72 hours after death with the Maryland at Hygiene. A the Hygiene of the than "natural", or ferms 23a or 28a-f show other than "natural", or ferm a the notified at event, the Medical Examiner must be notified at	Funerai	11. Marital Status	ui t	12. Was Dec	edent Ever in l	J.S. 13.	1			igin? (Spe	cify Yes or No	USA -		nencan Indian,	
0	or Iten	Fun	1 Never Married 2	Married	Armed Fo	orces? 2□No Ret		If Yes, spec	rfy Cubai	n, Mexica	n, Puerto f	Rican, etc.)		Black, Wi	nite, etc.	
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<u>a</u>		To Be	Earl Henry Smit	h						Leor	nore 1	Vixon				
			19a. Informant's Name/Re		ype, Print)			-				l Route Numb			, Zip Code)	
Σ	and 2 Balth a n 27 Is		Linda B. Smith/	Wife			_					ngton, M	D. 20	744		
Baltimore,	Pages 1 nent of Ho int: If itsr iry or oth		20a. Method of Disposition 1 Burial 2 Crem		Removal from	State	Place of Disp cemetery, cre		ne of ther place	1		ate	20c. L	ocation - City	or Town, State	
Ē	permit. Pag Department Important: any injury once.		`4 □Donation 5 □ O	her (Specify)	Ka	las Cren	_			5/24/05			water,MD		
Ba	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral S	ervice Licen	see						-	ge P. Kai Hill, Md			ome	
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	/Medical		disease or condition resulting in death)			ATHIC P (or as a conse		RY FIR	ROS1	LS.					4 YEARS	
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	res the igned l be det		Part II. Other significant c EMPHYSEMA	onditions co	ontributing to o	leath but not re	sulting in the	underlying ca	ause give	en in Part	1.			_	to the cause of de Probably 4 DU	
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ō	g Phy ter thi	n:T	27. Manner of Death			of Injury oth, Day Year)	28b. Time		Bc. Injury Work	at		28d. Describe			Journ	
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Division of	_ 0	Certification;	3 Suicide 6 4 Homicide	Could not be determined	289. Plac	e of Injury - At I ling, etc. <i>(Spec</i>	nome, farm, s	treet, factory	, office		2	28f. Location (City or To	Street ar wn, State	nd Number or e)	Rural Route Numi	ber,
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	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of	certifier				- 1		a number			29d. Da	ite signed (Mo	nth, Day, Year)	
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			DAVID A. NOI					ER RD.	ANI	REWS	AFB,	MD 20	762			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No) 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 21, 2005 15:37P [™] Kathlean Sheridan June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Prince George Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√□ F 67 Director 247-66-3173 Sept. 8, 1937 South Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Prince George Camp Springs 10e. Street and Number 10q. Citizen of What Country? 10f. Zip Code death with ō 6015 Walton Avenue 20746 United States or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status o filed within 72 hours after down thygiene.

Hygiene.

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1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 Yes 2 No 3 Probably 4 Unknown Completed peeu Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ate has page 2 s autopsy performe 2 No 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA nours after death. naral Diractor: After this y filled in by the funeral d 27. May er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred at or Attending F Injury 1 Natural (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0062167 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Surratts Rd. Clinton, MD, 20735 31. Date filed (Month, Day, Year)

JUN 2 4 2005 32. Registrar's Signatur State Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		of Health a of Death				005	22546
	Physici		1. Decedent's Name (First, Middle, Last) Robert L. Smit						2. Date of Dea Month June 1	Day	Year 2005	3. Time of Death 6:00 A
	/Medio Examir		4a. Facility Name (If not institution, give 9412 Wellington §				wn, or Location of	of Death		4c.	County of Dea	
	Funeral Director		5. Social Security Number 6. Sec. 223–40–5756		9 (In yrs. last birthday 9 Yrs.	If Under 1 Y Months D	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 8-1-19	h y, <i>Year)</i> 135	0	thplace (State or Foreign ountry) rginia
	se Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	eorge's	10c. City, Town or L Seab	rook						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Dire	10e. Street and Number 9412 Wellington S	S+ .		10f. Zip Co	ode 10716			10g, Citi	zen of What C US	•
9036	be tiled within 72 hours after death with the Maryland nat Hygiene. do other than "natural", or items 23a or 28a-1 show event, the Medical Examinat must be notified at	d by Funeral Director		12. Was Decedent Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	ło		t of Hispanic Ori Cuban, Mexican		ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi	erican Indian,
Baltimore, Maryland 21215-0036	d within 72 h jiene. r than "natu the Medical	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation e <i>completed)</i> College (1-4or 5	+) (Give	edent's Usual O e kind of work d DO NOT use n lesman	lone durina mos	t of worki	ng		nd of Business .nting {	Vindustry Supplies
/land	a la b	To Be C	17. Father's Name (First, Middle, Last) Emmett Smith				18. Mothe		(First, Middle, ra Jord	Maiden		
, Mar)			19a. Informant's Name/Relationship (Ty Margaret B. Smith)		941	2 Welli	ngton S			k. M	D 2071	5
more	Pages 1 am ment of Heali ant: If Item 2 ury or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donatjon 5 ☐ Other (Specify)	lemoval from State	20b. Place of Disp cemetery, cre Lakemont	matory or other	r place)	ء · -23–6			,	Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	98						Kal	as Fune	eral Home 4D 21037
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Aspirat Due to (or as	the death. Do not ente. ion pneumona consequence of): son's Dise.	onia	f dying, such as	cardiac o	or respiratory an	rest,		Approximate interval Between Onset and Death 2 Weeks 5 years
8760,	sate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	a consequence of):							
O. Box 6	I the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregn ⊒ Other (specif				2	23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed b should be det	by	Part II. Other significant conditions cor Diabetes mellitu		ut not resulting in the	underlying caus	e given in Part I			obacco u /es 2 [_	o the cause of death? robably 4 Unknown
of Vital Records,		Completed									24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			Othor		(Check only o			
	ling After funer	ition; To	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Inju	y 28b. Time		Injury at Work?	2	me 5 XResid 28d. Describe h			ecify)
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At home, farm, s c. (Specify)	reet, factory, of	ffice	-	28f. Location (S City or Tov			ural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	th occurred at the occurred at	he time, date an my opinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner a I place, and du	s stated. e to the cause(s)
1	To with To t	Σ	29b. Signature and title of certifier	/	mp		52503				e signed <i>(Mon</i> June 20	
•			30. Name and address of person who con 1221 Mercantile I		eath (Item 23a) (Type	, Print) Sha		heth,	, M.D.		Z(2005
	Sta Registi		31. Date filed (Month, Day, Year),	. Registra	ar's Signature	note:						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** $A^{\ M}$ HELEN TAM 2Ö 2005 8:28 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 13, 1941 9. Birthplace (State or Foreign Country)
China 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 63 577.64.6299 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show event, the Medical Examinant cost be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 131 Amberleigh Drive 20905 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 Is marked other than "naturel", or Ite ☐Yes 2 Yes, Give 1 ☐ Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Asian þ lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Restaurant Owner Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tam Shun Shui Szeto other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Tang/Husband 131 Amberleigh Drive, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Dep rtment Importent: If any injury or once Gate of Heaven Ceme. 06/25/2005 Silver Spring, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904
Address of Facility
Approximate 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fnysician ardiogenic /Medical **Examiner** week Sequentially list conditions, if any, leading to immediate outer and Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Ihree Yea Due to (or as a consequence of): Box 68760. physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 2**X** No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performen: 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death, I Director: Al 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medical npletely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 37960 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. TAKOMA PARK, Md. 20912 7901 MAPIE SUNG Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 4 2005 Registrar

	1	For State Registrar		State of	Marylan		artment of rtificate of				giene Reg. No.	00	5	22548	
		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ith Day	Υ	eer_	3. Time of Death	
Physician /Medical	ı.		MMIE		CARO,	JR.				06	25		25	0433 M	_
Examiner	4	la. Facility Name (If not institution	n, give st	reet and numb Media		fil	4b. City, Town	or Location	of Death		4c. (County of	Death,	•0	
	5	5. Social Security Number	6. Sex		. Age (In yrs.		If Under 1 Yea		24 Hrs.	8. Date of Birth	h		. Birthp	lace (State or Foreign	_
Funeral Director		579-24-9577		M 2□F	79	Yrs.	Months Day	s Hours	Min.	(Month, Day	v, Year) 0 , 19		Coun	H., DC	
9		Usual Residence of Decedent			100 6	y, Town or L								0d. Inside City Limits	_
shov		10a. State 10b. County											,	1 ☐ Yes 2 ☐XNo	
vith the Mar or 28a-f s be nutilised	1	MARYLAND CHAI	RLES	5	WA	LDORE	10f. Zip Code)			10g. Citiz	en of Wh	at Coun	itry?	-
5-0036 72 hours after death with the Maryland netural; or Items 23s or 28s-f show licel Examiner must be netilised at seed by Europea Director	5	8750 PAPER B	TRCE	н ст.				20603	}		Ţ	J.S.	Α.		
of Items 23e	5	11. Marital Status		2. Was Deced	ent Ever in U	.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Or	rigin? (Spe	ecify Yes or No-	- 1		Americ White,	an Indian,	-
or Ite	3	1 Never Married XXMar		1 X Yes 2 If Yes, Give	No		1 ☐ Yes 2X☐X			1110411, 0101,		Specify:		ITE	
215-0036 thin 72 hours afficient and "netural", or the distribution of the distributio	2 -	3 Widowed 4 Divorced		Year or Da	es: WWI	_	dent's Usual Occ	unation		I	16h Kir	nd of Busi			_
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laryland 212. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ITAM		17. Father's Name (First, Middle	Last)					18. Moth	ner's Name	e (First, Middle,		Sumame)			
should be in which we want to eve		CAMILLO VA	CCAF	20			-	ANN		SONNT					
Maryland d 2 should be file th and Mental Hy E7 Is marked oth traumatic event		19a. Informant's Name/Relation	ship (Typ	oe, Print)		19b. Mail	ing Address (Stre	et and Numb	ber or Rura	al Route Numbe	er, City or	r Town, St	ate, Zip	Code)	
⊆ ल '	-	RUTH VACCAR 20a. Method of Disposition	0-W.	IFE		Place of Disp	PAPER osition (Name of			Date WAL				0603 own, State	_
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	1	21. Signature of Funeral Service		e MOC	479		2 Name and Ad			. / 1	05 (71111	T T7.74	HAM MD	
Balt permit Depart Import any in,		Michan	00	7			RAYMON								
		23a. Part1. Enter the disease, c shock, or heart failure. Lis	r complice t only on	cations that ca	used the dea	th. Do not er	nter the mode of	tying, such a	S GARIAGE	of respitatory ai	Mes, 40)		Approximate Interval Between Onset and Death	
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/Medical Examiner	1	resulting in death)			or as a consec		ind sind	5	1-14.	h				to See	
		Sequentially list conditions, if any, leading to immediate	ь		or as a consec				(Cont	- Carl			-	طهو ا	-
d uted ansit	Examin	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	'	80	J	13	go Kale	www						of gods	
O, o o o o o o o o o o o o o o o o o o o	EX	resulting in death) Last	Ĭ	Due to (or as onse	quence of):	70								
sayeo, Ecate be executed physician and the burial-transit	lical		o										-		
Box 68 leath certifics attending ph		IF FEMALE:	2	3c. If yes, out	come of pream	ancy					Π,	23d. Date	of dollar		
Geath cert	משוני	23b. Was decedent pregnant in the past 12 months?	-	1☐Live bi	rth 2 ☐ Fet	al death 3	☐Ectopic pregna ☐ Other (specify					Mont		Day Year	
Check the	Jysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno											
ords, Prequires that	by Physician/Me	Part II. Other significant condit	ions con	tributing to de	ath but not re	sulting in the	underlying cause	given in Par	t I.	23e. Did t	tobacco u	1		he cause of death?	
										1 🗆	Yes 2	ZNo 3	Prob	pably 4 □Unknown	
Pecce law r	Completed									24a. Was auto	DSV	pr	ior to co	opsy findings available empletion of cause of	
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of Vital F Physician: Th this certificate ral director, pag	ne	25. Was case referred to medic examiner?		lospital:				Other		h (Check anly o					_
A Sign	0	1 Yes 2 No 27. Manner of Death		1	npatient 2 of Injury h, Day Year)	ER/Outpati 28b. Time	of 28c.1	njury at	Nursing Ho	ome 5 Resi 28d. Describe				fy)	-
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Division Il or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be mined	28e. Place	ol Injury - At I	nome, farm,	street, factory, off	св		28f. Location (City or To			r or Run	al Route Number,	
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T will) Nem	ال					OVYC		-		5.0	5. 1	2005	
		30. Name and address of person	n who co	ompleted caus	e of death (Ite	em 23a) (Typ	e, Print)							0.6	_
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DHMH 17 Rev 1/2001

Vaccaro, Camillo

		-	For State Registrer	Stat	e of Ma	ryland	_	artmen			ınd M	ental Hy	giene	20()5	225	49
			Decedent's Name (First, Middle	, Last)								2. Date of Dea			Year	3. Time o	1 0
	Physicia /Medic		Gregory				Wrigh	t				June 18	, 20	05	1 Oal	17:59	РМ
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			Southern Mary				n é la lada da)	C If Under	lint	on If Under:	04 Hrs	9. Date of Bird		Prin		eorge'	
	Funeral Director		5. Social Security Number 579-68-7445 Usual Residence of Decedent	6. Sex 1⊠M 2□	-	54	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da April 5		51	Was	place (State ntry) hingto	n,DC
	/land		10a. State 10b. County			10c. City,	Town or Lo	cation								10d. Inside C	City Limits
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	or 28	Oire	10e. Street and Number					10f. Zip					-		What Cou	ntry?	
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36	tiled within 72 hours atter death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28e-f ehow ther the Medical Evanil at must be rollified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Divorced	ied 1 23	Decedent E ed Forces? Yes 2 \ N es, Give r or Dates:		У	was Deced If Yes, spec	1	Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)		Specify	ck, White, B	fack	
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215	within 7 iene. • then "r	Completed	Elementary/Secondary (0-12)		ege (1-4or 5	i+)	life.	DO NOT us	se retired)	or work	9					
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and	e d al a	Be	Allandus Wrig									Smith	Maidell	Suman	110)		
Maryland 21215-0036	s 1 and 2 should be filed if Health and Mental Hygi Item 27 le marked other other treumatic event, I	2	19a. Informant's Name/Relations		t)		19b. Maili	ng Address	(Street a			I Route Numb	er, City o	r Town,	State, Zi	p Code) 2	20744
	12 a		Shelia Thomas-	Wright/	Wife		7269	Wood	ho11	ow Te	rrac	e Ft. V	lash:	ingt	on,M	arylar	nd
Baltimore,	ss 1 and 3 of Health item 27 other tr	Νĵ	20a. Method of Disposition	2 D	4 C1-4-	20b. Pla	ace of Dispo	sition (Nar.	ne of ther plac	9)	C	ate	20c. Lo	ocation -	- City or T	own, State	
Ē	Pages nent of H sent: If ite ury or of		1 ☑Surial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5		from State	l	mony				5/24/	05	Land	ovei	,Mar	yland	
Salt	permit. Pages Department of Importent: If i any injury or once.		21 Ignature of Funeral Secret	Liceass e		/		2. Name an				B. Je					
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Vital	ysicien: The is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital			•		Oth		e of Deat	n (Check only	one)				
of	S S	1.	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 Inpatie	- 1	ER/Outpatie 28b. Time o		JA	4 L N	_	me 5 Resi 28d. Describe		_		ify)	
O	ding I h. After funer	tion	1 Z Natural 5 ☐ Pendi		(Month, Da	y Year)	Injury	м	28c. Injur Wor 1 🗌	k? Yes 2.⊠	1		,-	.,			
Division	To the Hespitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could 4 Homicide deterr	not be	Place of Inj building, et	ury - At ho c. (Specify	me, farm, si	reet, factor	y, office			28f. Location (City or To			ber or Ru	ral Route Nu	mber,
	To the Hespitel within 24 hours a To the Funerel Completely filled	Medicai C		ng Physician: Exeminer: Or an		f examinat											(s)
	To th withir To th comp	M	29b. Signature and titlenof certific	0				29		e number	119	5	29d. Da	te signe	Month 200	. <i>Day, Year)</i>	
_	(10)		30. Name and address of person	who complete	EK E	201	Ft V	VASIT	NGG	1ermo	Cur	a M.D.	144	¥	7		
	Sta Regist	ate rar	31. Date filed (Month 1944). 29a/	2 2005	32. Tegistr	rars Signal	ture	book	,								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, **Physician** 2005 3:28 P. M June White Marion Emma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's HCR Manor Care Largo If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Hours 1 □ M 20%F 74 Yrs. Wash., D.C. 10/1/30 Director 231-30-2833 Usual Residence of Deceden tiled within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b, County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Washington 12 Yes 2 □ No D.C. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 U.S.A. 5100 B St., S.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black White ietcan-1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: American 1 ☐ Yes 2 ☒ No Specify: δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Domestic 12th permit. Pages 1 and 2 should be tiled v Department of Health and Mental Hygies Important: If Item 27 is marked other th any injury or other traumatic event, Illas 2006. 18. Mother's Name (First, Middle, Maiden Sumame)
Emma Jean Williams 17. Father's Name (First, Middle, Last) Be Joseph (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Reginald C. Williams/Son 5710 Birchview Pl., Clinton, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/22/05 Harmony Mem. Park Landover, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 22 And Address of Facility & Sons Co., Inc. 21. Signature of Funeral Service Licensee and 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1110 has /Medical Due to (or as a con squence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): by Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for us 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nonknown been si Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this After this 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di completely tilled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 226 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Feldman, M.D. 9500 Annapolis Road # A-4, Lanham, Md. 20706 31. Date filed (Month, Day, Year) State JUN 2 2 2005 Registrar

Baltimore, Maryland 21215-0036

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Division of Vital Records,

			For State Registrar	State o	f Marylar		artment of H				iene) =	22551
		29.1	Decedent's Name (First, Middle	, Last)						2. Date of Deat		J.J	3. Time of Death
	Physici /Medic		Helen Frances							June	24, 2	Year 005	4:30 A ^M
	Examin	er	4a. Facility Name (If not institution		mber)		4b. City, Town, or	Location of	of Death		4c. County		-
	Funeral	54.	Berlin Nursing 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Berlin If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	Worce		lace (State or Foreign try)
- 6	Director		219-20-4543	1 □ M 2 🕌 F	77	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, 3/22/1	928	MD	itry)
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits
	ours after death with the Marylan ral', or itams 23c or 28a-f show Examinar must be mutified at	tor	MD Word	ester		Berlin							1 ☐ Yes 2 X No
	th the	Director	10e. Street and Number			201111	10f. Zip Code			1	0g. Citizen of	What Coun	itry?
	ath wi	rai	8213 Shire Dr.				218				US		
	itams itams	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	Armed Fo	edent Ever in U rces? 2 (X No	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori ın, Mexicar	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	14. Rad Blad	ce - Americ ck, White,	
936	ursaf	þ	3 □ Widowed 4 □ Divorced	If Yes, Giv Year or D	/8		1 ☐ Yes 2 🛣 No	Specify:			Specif	w: Wh	nite
5-0	d be filed within 72 hours a Intal Hygiene. ad othar than "natural", o s avant, the Nedles Enan	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usual Occupi kind of work done of DO NOT use retired	ation during mos	t of workin	g	16b. Kind of B	usiness/Ind	dustry
121	within ane. than '	idui	Elementary/Secondary (0-12)	College (1	1-4or 5+)		DO NOT use retired Homemake				0	. 11a	
sh nd 2	Hygin othar ant, I	Be Co	17. Father's Name (First, Middle, I	_ast)			Tomemake		er's Name	(First, Middle, I		n Ho	me
als //an	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Itams 23c or 28a-f show aumatic avant, the Medical Eventiner must be ricitified at	To B	Roy Graham					Le	eila E	Burns			
. Walsh Maryland 21215-0036	2 sho and I is ma		19a. Informant's Name/Relationsh			1	ng Address (Street				•	State, Zip	Code)
•	s 1 and 2 should f Health and Men itam 27 is marks othar traumatic		Charles H. Wa 20a. Method of Disposition	Ish/Husb			Shire D				21811 20c. Location -	- City or To	wn State
en	Pages nent of int: if its iry or o		1 Burial 2 Cremation 4 Donation 5 Other (S)		JIAIO		sition (Name of matory or other place nlopen Cr	1	6/20				
⊢	permit. Pages 1 an Department of Heali Important: if itam 2 any injury or othar ance.		21. Signature of Funeral Service I		T Co		Name and Addres						al Home
He Bal	99 = 89		1 Tacqueline	7. 0	effect		8 William		Ber	lin, MD	21811		
			23a. Part1. Enter the disease, or shock, or heart failure. List				er the mode of dyin	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	arcin		of VI	he	410	~			(ear)
	Examiner				(or as a conse	quence or):							
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	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of):							
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œ	tificate ng phy as the	fedic		- u									
30X	death certifica attending ph d for use as th	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		oirth 2 ☐ Fet	al death 3	Ectopic pregnancy					ite of delive	ry Day Year
0	the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□ Unkn	nant at time of own	death 5	Other (specify)						
Division of Vital Records, P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Рh	Part II. Other significant condition	ns contributing to de	eath but not re	sulting in the u	nderlying cause give	en in Part I		23e. Did tot	bacco use conf	tribute to th	e cause of death?
ords	w require been sig should b									1 □ Y€	es 2□No	3 🗌 Prob	ably 4 Unknown
ecc	has be	Completed								24a. Was a autops	SV	prior to cor	psy findings available inpletion of cause of
al H	iician: The l certificate ha rector, page										2 NO	death? 1 🗌 Yes	2 No
V.	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 € No	Hospital:	Inpatient 2] ER/Outpatier	nt 3 DOA Oth	or V		(Check only on ne 5 ☐ Reside		ner (Snecifi	()
οι	ding Phys	n: T	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date	of Injury th, Day Year)	28b. Time or Injury		v at		8d. Describe ho			,
sioi	ttandir death. stor: Af	catic	2 Accident investig	ation			M 1	Yes 2					
Divi	l or Attano after death Diractor: I in by the	Certification;	4 Homicide determ	ned 289. Place	of Injury - At I ing, etc. <i>(Spec</i>	nome, farm, str ify)	eet, factory, office		2	81. Location (St City or Town	treet and Numb n, State)	oer or Hura	l Route Number,
_	To tha Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifica completely filled in by the funeral director, to	aiC	29a. Certifier Sertifyin	g Physician: To the	best of my kn	owledge, deat	h occurred at the tin	ne, date an	nd place, a	nd due to the ca	ause(s) and ma	anner as st	ated.
	tha Ho lin 24 the Fu	ledical	one)	examiner: On the b	asis of examin ner stated.	ation and/or in			ath occurre				
	To To	Σ	29b. Signature and the of certifier	weed.	/ '	7	> 29c. Licenso		69		9d. Date signe		
	_,		30 Mamb and address of person	who completed caus	se of death (Ite	m 23a) (Type,	Print) /	11	//	7	1	0	05 1, De 1994
C_{i}	H.5		Nicholes Bo	rodulea	gistrario Sian) /2	09 was	, tel	Huy	, 19	will	45	l, We 1994
	Sta Registi		31. Date filed (Month) Y2"	2005	gistrar's Sign	BA	and o						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jພືໂຶy 8,2005 Henry Thomas Artes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Morningside House | Months | Days | Hours | Min. | Sept. 18, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 90 213-01-1213 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intern 27 Is marked other then "naturel", or Items 23s or 28s-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h. Counts treumetic event, the Mudical Examiner must be notified at 1 ☐Yes 2 ☐ No Completed by Funeral Director N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5206 Catalpha Road 21214 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White WWII 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Monumental Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lily Ryan Henry Artes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21214 3505 Gibbons Avenue Martin J. Artes- Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ŏ permit. Page Department of Important: If any injury or once. Parkwood Cemetery 7/12/05 Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather 5305 Harford Road Baltimore, Maryland 21214 Coatle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4-pars MIZIHEIMI resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 5 signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 7 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed 1 Yes 2 No 1 Yes 20 No Hospitel or Attending Physicien: 34 hours after death, Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

JUL 1 1 2005

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MANISH SINGH

RESIDENT

32. Registrar's Signature

MOSPITAL,

AS 24385283699 JULY, 08, 2005

9005 CATON AVENUE, BALTIMORE, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Day 2005 7:56P **Physician** BEVERLY JANE BAUER 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | December 21,1921 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M % F 217-16-5458 Yrs. Director New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No Directo Baltimore Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or tre Medical Examiner must be a 26 Dunvale Road Apt D 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify þ 3√XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Hugh DeForrest Sherman Reva Eleanor Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trat once. Susan J Bauer Dtr 15525 Mattfeldt Avenue Baltimore Maryland 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Parkwood Cemetery 7/11/05 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Septice, Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** - una /Medical Due to (or as a con-**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Dicease of injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicisn and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \)
No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has b ormed? 2 Di No certificate 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) HOSpice ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha I tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43725 7/7/05 2300 Dulaney Valley RD Timonium, HD 21093 7/7/05 4

State Registrar

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DHMH 17 Rev 1/2001

aria 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood, MD

32. Recentrar's Signature

		-	. FUI	artment of Health and Mental Hy tificate of Death	/giene Reg. No. 2005 22555
	Physicia	an	Decedent's Name (First, Middle, Last)	BARIZE N JULY	eath Day Year 3.4 Time of Death D
	/Medic Examin Funeral	er	PATRICIA 4a. Facility Name (If not institution, give street and number) The John's North Andrew 5. Social Security Number 6. Sek 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Compared to the content of	4c. County of Death
	Director		092-34-6368		12, 1942 New York
	Maryle -f ehov	ţō	Maryland Montgomery Kensin		1 ☐ Yes 2Ž No
	vith the	Funeral Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death v	neral	5211 Strathmore Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. y	20895 Was Decedent of Hispanic Origin? (Specify Yes or N	United States o- 14. Race - American Indian,
036	al', or ite	β	1 Never Married 2 N Married 1 ☐ Yes 2 N No	lf Yes, specify Cuban, Mexican, Puérto Rican, etc.) 1 □ Yes 2🌠 No <i>Specify:</i>	Black, White, etc. Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow eny injury or other treumatic event, Ite Medical Examinar must be notified at once.	Completed	(Specify only highest grade completed) (Give life. L	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
d 21	filed w Hygier ther th		3 Reg1s	stered Nurse 18. Mother's Name (First, Middle)	Hospital e, Maiden Sumame)
Maryland	Aental Aental rked o	To Be	John Barren	Betty Schult	:z
Many	2 short and h			ng Address (Street and Number or Rural Route Num	
	is 1 and 2 of Health a ltem 27 is other treu		20a Method of Disposition 20b. Place of Dispo	Strathmore Avenue, Kens sition (Name of matory or other place) July 9,	20c. Location - City or Town, State
OE E	Pages nent of int: If If iry or o		1 Burial 2 Cremation 3 Hemoval from State	Crematorium, Inc. 2005	Bethesda, Maryland
Baltimore,	permit. Departn Imports eny inju		21. Signature of Funeral Service Liversee Ro 75.	R. Name and Address of Facility bert A. Pumphrey Funeral Home 57 Wisconsin Avenue, Bethesda	e/Bethesda-Chevy Chase, Inc. a, Maryland 20814-3501
	Physician		23a. Part1. Enforthe disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. HEPATIC FAILURE	er the mode of dying, such as cardiac or respiratory	Approximate Interval Between Onset and Death
8760,	Medical Examiner whysician and the burial-transit	Icai Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
.O. Box 68	ne death certific the attending p	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Δ.	es tha	by	Part II. Other significant conditions contributing to death but not resulting in the u		d tobacco use contribute to the cause of death?
Records,	The te his	Completed			prior to completion of cause of death?
Vital	lcian: certifical ector, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only	
of	Phyer this ral dir	To :	1 ☐ Yes 22 No Hospital: Inpatient 2 ☐ ER/Outpatien 27. Manner of Deat 28a. Date of Injury 28b. Time of		sidence 6 Other (Specify) e how injury occurred
Division	Attending I ir death. actor: After by the funer	Certification;	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 4 □ Homicide determined	M 1 Yes 2 No	(Street and Number or Rural Route Number, own, State)
Ö	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by t			th occurred at the time, date and place, and due to the	ne cause(s) and manner as stated.
	the H thin 24 the F mplete	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	T viit		TEXHIM MO	D58902	JULY 3, 2005
	7		30. Name and address of terson who completed cause of death (Item 23a) (Type.	, Print)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	U		DAVID WANG, MD JOHNS HOLKINS HOSPITA 31 Date filed (Month Day Year)	AL, 600 NORTH WOLFE STREET	F BACTIMORE MARYLAND 2128
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 2005 32. Registrar's Signature	W.	

with the Maryland ir than "naturel", or items 23e or 28e-f shov If e Woolcal Examinar must be notified at filed within 72 hours after Department of Health and Mental Hygien Importent: If item 27 is marked other tha any injury or other treuments.

Patient known as

Priysician /Medical Examiner

burial-1 attending physician for use as the buria certificate be use as t ed by the a detached f been signed be should be deta After thi

Division of Vital Records, P.O. Box 68760. or Attending Physician: s after death. completely filled in by within 24 hours a 3

Reg. No. 2 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 10 35 PM Yea 2005 FRANCES Ι. BELLE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore Sinai Hospital of Baltimore City If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Day, Year) MAR. 15, 1904 9. Birthplace (State or Foreign NEW JERSEY 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔽 F 101 Yrs. 218-36-7176 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A Funeral Director MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2500 WEST BELVEDERE AVENUE #316 21215 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 💥 No Specify: WHITE Specify: Be Completed by 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ISRAEL BANNER (UNOBTAINABLE) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARRY BELLE / SON 4115 WINTERHAZEL ROAD - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK! 07/08/2005 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final myocardial one dan disease or condition resulting in death) Due to (or as a conseq -nce of): 40 years Hypertension Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Heart Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25 No 1 Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number folf Kenty, MD RES - 000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. KREUTZ, MD, Sinai Hospital of Baltimore 31. Date filed (Month, Day, Year) JUL 1 1 2005 . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				For State	State of Ma						and M	ental Hyg	giene	3		
		Physicia	an	1 - State Registrar AMEND ITEM 1. Decedent's Name (First, Middle, Last)	#19b PER	INF	G845	7/28/	65° J#	eau i		2. Date of Dea Month	th Say	20(5 Year	2Time StoSkh7
		/Medic	al	CATHERINE C. (1 1 1 1 1 1	(5 "	JUNE 2	9,	200		4:30 PM
		Examin	er	4a. Facility Name (If not institution, give s		CEN	mpp	4b. City,		Location of		1		County o		O E
				MILFORD MANOR I 5. Social Security Number 6. Sex			ILK last birthday)	If Under		If Under		8. Date of Birtl				
		Funeral Director			14 a 🗆 🗆	32	Yrs.	Months		Hours	Min.	AUG. 16	Year)	923	Cour M A	lace (State or Foreign stry) RYLAND
	7			Usual Residence of Decedent	21	,						1100.10	, ,	727		
	1	yian how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City Limits
	2	r 28a-f show	ţċ	MD. N/A		BA	LTIMO	RE								1 ☐ Yes 2 ☑ No
	1	or 28	ire	10e. Street and Number				10f. Zip					-	zen of W		itry?
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2	036	within 72 nouts after death with the maryland ene. Then "natural", or items 23e or 28e-f show fre Mcdicel Examination and the multifect at	by Funeral Director	11. Marital Status X 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 			Was Dece If Yes, spe 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)		14. Race Black BLA Specify:	. White.	an Indian, etc.
-	215-0036	a within 72 hours jiene. r than "natural", fre Mudical Exa	Completed	15. Decedent's Educ (Specify only highest grade	completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done d se retired	ation furing mos	t of workii	ng	16b. Ki	nd of Bus	iness/In	dustry
athrome	212		шо	Elementary/Secondary (0-12) 12TH	College (1-4or 5			ABOR					E	ZODD	FDC	COMPANY
3		the the	BeC	17. Father's Name (First, Middle, Last)	Z I EAI	7-0	<u> </u>	ADOM	LIK	18. Mothe	r's Name	(First, Middle,				COMPANI
Š	la l	Hental Hental rked o	To B	PRANCIS CHEW							ת ל ל לים	CHEW				
	Maryland	and Menistre sammatic		19a. Informant's Name/Relationship (Type	oe, Print)		12651	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	r, City o	r Town, S	State, Zip	Code)
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	altimore,	Page ment o ant: If ury or		20a Metroo of Disposition 1 Disposition 1 Donation 5 Other (Specify)	emoval from State	20b. F	Place of Dispo Cemetery Cre ZTC	natory CE	me of ther plac ME T	ĒRY	7/7/	05 I				MARYLAND
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	٥	res that igned by be deta		Part II. Other significant conditions con	tributing to death b	ut not res	sulting in the u	ınderlying	ause give	en in Part I		23e. Did to	obacco u	ise contri	bute to tl	ne cause of death?
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	tal	uctan: In certificate rector, pag	a)	25. Was case referred to medical						26. Place	of Death	(Check only o	_		_ 163	20110
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	0	aing Phys n. After this funeral di	T:U	27. Manner of Death	28a. Date of Inju (Month, Da	ry V Year)	28b. Time o	of :	28c. Injury Work	at		28d. Describe I	now injur	y occurre	d	
	0	rtending death.	atic	1	(, ,	,	М		Yes 2□	No					
	Division of Vital Records, P.O. Box 6	or Attendate after death Diractor: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At h	nome, farm, st	reet, factor	y, office			28f. Location (5 City or Tox	Street an vn, State	d Numbe	r or Rura	il Route Number,
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		fo the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	sicien: To the best ner: On the basis of and manner st	f examina	owledge, deal ation and/or in	th occurred ivestigation	at the time n, in my of	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) date and	and mar i place, a	nner as s nd due to	tated. the cause(s)
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		. 2		30. Name and address of person who co		leath (Ite	m 23a) (Type.							1		
				Kaynou Mille		Maria		1 5	vle	200	Re	nokslawa	^	Q^		
		Sta Registi		31. Date filed July, Pay 1 2005	32. Registr	rar's Jian	ature									

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 11:00 a **Physician** July 10, Cox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Harmony Hall 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 90 Yrs. Director 220-30-2571 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Marical Ferral Anglical Ferral Anglical 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Md. Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6110 Covington Rd. 21044 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 + 3 Registered Nurse Seton Institute 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Koermaier Mary Harter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Covington Rd., Columbia, Md. 21044 Joan C. Lancos - Daughter 20a. Mathod of Disposition
1 ➡ Burial 2 ➡ Cremation 3 ➡ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Druid Ridge Cem. July 14, 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Md. 21. Signature of Furter | Service Licer 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician Tract disease or condition resulting in death) Vrinary weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the e 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Althemers 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 2 7 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural s after dec. -al Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 10100 Charter Mrz Columbia MO 21094 MO 30. Name and address of person who completed cause of death (item 23a) (Type, Print) HOVIN CARLSON MO 2. Registrar's Signature 31. Date filed (Month, Day, Year) 1 1 2005 Registrar

			For State Registrar	State of	Marylan		artment of H rtificate of I			giene Reg. No2 ()	05	22559
I	Physici		1. Decedent's Name (First, Middle, La Arlene Hare Cra						2. Date of Dea		Year	3. Time of Death 12:30 a.M
	/Medic Examin		4a. Fecility Name (If not institution, give Long View Nursing		ber)	-	, , ,	Location of Death			ty of Death	
	Funeral Director		Social Security Number 6. S		'. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	h	9. Birtho	lace (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					0d. Inside City Limits
	e Mary 3a-f sho	Director	Maryland Carroll		Ma	nchest	er					1 No 2 No
	a with th		10e. Street and Number 3147 Main St.				10f. Zip Code 21102			10g. Citizen of U.S.		try?
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Evertine must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Delivorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Da	ces? ? 🚮 No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp.n, Mexican, Puerto	pecify Yes or No- Pican, etc.)	Bla	ace - Americack, White,	etc.
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and		To Be (17. Father's Name (First, Middle, Last, Howard Hare)				18. Mother's Nam Diliah	ne (First, Middle, Richart		me)	
Maryland	d2: thar trau	-	19a. Informant's Name/Relationship (Allen R. Craft,		1	19b. Mailir 3147	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town	n, State, Zip	Code)
			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from S	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	θ)	Date	20c. Location	- City or To	wn, State
Baltimore,	permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specifical Service Licentification of Funeral Service Licen		Laz		hurch Cer khardt ri 96 Charmi					
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60,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	C. Due to (c	r as a consequ	uence of);						
68760,		ledicai		_ d								
.O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)			4	ate of delive	ny Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	contributing to dea	ath but not resu	ulting in the u	nderlying cause give	en in Part I.				e cause of death?
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on of		lon;	27. Manner of Death 1 Natural 5 Pending		Injury , Day Year)	28b. Time of Injury	Work	The state of the s	28d. Describe h			,
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	To the Hospital or within 24 hours after Within 24 hours after To the Funeral Direct completely filled in E	Medical C	29a. Certifier Check only 2 Medicel Exer	nysician: To the to niner: On the bar and manner	sis of examinat	wledge, death tion and/or inv	occurred at the time vestigation, in my op	ie, date and place, pinion, death occur	and due to the or	cause(s) and material	nanner as st , and due to	ated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. License	7316	-	29d. Date sign	ed (Month, I	Day, Year)
i	17		30. Name and address of person who	completed cause	of death (Item	23a) (Type,		~ D.(.	No	1 1 -) n	221:074
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 1 2005	7 32. Re	gistrar's Signa	Speed	E)	9		1.		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 0 **Physician** July THOMAS 2005 6:00 7 LEO CLASH р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge 6295 West Rockburn Hill Road Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 2 🗆 F ¹XX Yrs. Director 364-26-8281 80 29, 1924 Michigan Usual Residence of Decedent with the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits or 28e-f show r than "natural", or items 23s or 28e-f showing Medical Examiner must be notified at 1. Yes 2 No Directo MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 8th Street 20707 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No If Yes, Give WWI Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WWII 1 ☐ Yes 2XXVo Specify: White ğ 3 XXidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any injury or other treumatic according Elementary/Secondary (0-12) College (1-4or 5+) Accountant years Industrial Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter Clash Mary Eischen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6295 West Rockburn Hill Road David P. Clash son Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XX remation 3 □Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 7/9/2005 Odenton, Maryland 21. Signature of Funeral 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 Laurel, Maryland 20707 313 Talbott Avenue 23a. Part1. Enter the sease, or comshock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Neoplasm, Lung 2 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗓 📆 📆 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2XXVo 2 X No Physicien: the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Nother (Specify) Residence Son's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 📉 📉 o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? after death. Director: After or Attending 1 XXatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitei o within 24 hours aft To the Funerei Di **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0036716 July 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Cherry Lane Andrew Kundrat, M.D. LAurel, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day)

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760

ORIGINAL

32. Reg

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death C'Astle-Antrell Edward 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Security Number Age (In yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthpla 12 M 2□F N/A Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location nside City Limits 1 ☐ Yes 2√XNo Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11706 S. Laurel Drive #3B 20708 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes ŽÍNo Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony E. Castle Katrina Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Brown grandmother 11706 S. Laurel, Drive #3B Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) National Mem. Park 7/11/2005 Laurel, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility al Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): CL Sequentially list conditions, if any, leading to inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Vatural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Physician/Medicai ed by the a cete has been signed , page 2 should be det

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nd 2 should be filed within 72 hours after death with the Marylar lith and Mental Hygiene. 27 is marked other then "natural", or items 23e or 28e-f show renamatic event, the Medical Examinating the trelified at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic ev 9DC8.

£nysician

/Medical

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3 Suicide

29a. Certifier

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Daje signed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

05

VIE OND 31. Date filed (Month, Day,

egistrar's Signature

300

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Year

Maryland

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Dey, Year)

July 3, 2005

3 Probably 4 Unknown

At scene

1 Yes 2 No

21223

within 24 hours at To the Funaral D completely filled in Hospitel To the

State

(Check only

29b. Signature and title of certifier

MDMAN MAN (Month, Day, Year) 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201 32. Pegistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

- No.		1 - For State Registrar			Certificate of	Death		Reg. No. 2	005	2250	
		1. Decedent's Name (First, Middle,	Last)				2. Date of De		Year	3. Time of Doard	
hysici: /Medic		BROOKLYN	CONILE	7			744	07,7	2005	8-4512!	
xamin		4a. Facility Name (If not institution,			4b. City, Town, o		ath	4c. Coun	ty of Death		
			HOSPITAL.		BALTI				18/7		
neral ector		5. Social Security Number 219-40-4493 Usual Residence of Decedent	6. Sex 7. Age	62	rthday) If Under 1 Year Months Days	If Under 24 H Hours M		th , 1943		ace (State or Forei Invland	
E 18		10a. State 10b. County		10c. City, Tow	m or Location			-	10	Od. Inside City Limit	
offfind	ector	Md.	N/A			ltimore				1 Yes 2 N	
alben	al Dir	10e. Street and Number 2709 Booker Drive			10f. Zip Code	21225		10g. Citizen o	U.S.A.		
ingrum ingrum	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ✗ Marrie			13. Was Decedent of H		(Specify Yes or No erto Rican, etc.)	14. Ra	ace - America lack, White, 6	etc.	
Evan	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 No			Spec	my.	ack 	
Medica	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade completed)		 Decedent's Usual Occup (Give kind of work done life. DO NOT use retire 	working		t. Royal Management Co.			
T. III	Com	12	College (1-4or 5	+)	Main	tenance					
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r traum		19a. Informant's Name/Relationsh Barbara Conley	ip (Type, Print)	198	2709 Booker D				n, State, Zip	Code)	
r othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	2 DD	20b. Place o	of Disposition (Name of ary, crematory or other pla	ce)	Date	20c. Location			
injury or		* 4 ☐ Donation 5 ☐ Other (Sp	ecify)		Oruid Ridge Ceme	etery	07/13/05	F	Pikesville,	Md.	
any injury		21. Signature of Funeral Service L	to //		22. Name and Addre	rothers Fur	neral Service I Baltimore, Mo	PA 121217			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month TOUBOSE NOHN 2005 June 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Breltinere Medical If Under 24 Hrs. 8. Date of Birth (Month, Dey, Y 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) SC Year) Months Days Hours 1X M 2□ F 70 Yrs 34 247-56-3348 Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Yes 2□No Baltimore NA 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21217 1510 Mosher Street Apt 4L 12. Wes Decedent Ever in U,S Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Freight Handler Canton Railroad 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lucille James Andrew Dubose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Stockmill Road Apt H, Pikesville Md 21208 Sharon Dubose-Wife 2 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 6/23/05 Randallstown, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one-cause on each line. Immediete Ceuse (Final disease or condition resulting in death) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

ng physiclen end es the burial-trensit

ettending physiclen for use es the buria

ate has been signed by the pega 2 should be detached

cartificate has

after daath. Director: After this

Attending

0

To the Hospital within 24 hours a To the Funeral D

completely filled in by the funerel

Certification:

Medical

The law requires that the deeth certificate be executed

Division of Vital Records, P.O.

Examiner

Physician

/Medical

Examiner

Director

Funeral

ð

Completed

Be

MD

Funeral

Director

filed within 72 hours efter deeth with the Meryland

altimore, Maryland 21215-0036

Pages 1 and 2 should be

Department of Health ar Important: If Item 27 is any injury or

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Physician/Medical þ Completed Be 2

29a, Certifier

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Menner of Death

1 Natural 2 Accident 5 Pending investigation 3 Suicide 4 ☐ Homicide

6 Could not be determined

1 Inpatient

Hospital:

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

TIENDING person who completed cause of death (Item 23e) (Type, Print)

MD

PAUL ST

1

Registrar

29b. Signature and title of certifier

82. Registrer's Signature

301

DHMH 16 Rev 6/95

ORIGINAL

			for State Registrar	State of Maryla	•	artment of I			giene		
	Physici /Medio		1. Decedent's Name (First, Middle, Las	r) -		Dansis	5	2. Date of Dea	- / -	705	27 650 650 Gth 5
	Examir Funeral	er	4a. Facility Name 4 not institution, give Here Held 5. Social Security Number 6. Security Number	x 7. Age (In yr	s. last birthday)	4b. City, Town, If Under 1 Year Months Days	or Location of Deat The Control of Deat If Under 24 Hrs	8. Date of Birt	4c. County	9. Birthpli Count	ace (State or Foreign
	Director tehow		217-18-6931 10 10 10 10 10 10 10	10c. 0	City, Town or Lo	ocation On Heig	hts	07/06	5/1915	Mary	rland Od. Inside City Limits 1 □ Yes 2 No
	with tha ? 3a or 28e-	Funeral Director	10e. Street and Number 1447 Kirkwood R		imorius	10f. Zip Code 2120			10g. Citizen of V		try?
920	igas 1 and 2 should be filad within 72 hours aftar daath with tha Maryland nt of Haatih and Mantal Hygiana. If item 27 is marked other then "natural", or itams 23a or 28e-f show or other traumatic event, the Medical Examinar mast be multified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces?, 1 Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. Rac	e - America k, White, e	an Indian, etc.
Maryland 21215-0036	ad within 72 ho /giana. er then "natu	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Stress	pation during most of wa ad)	rking	16b. Kind of Bu		ustry
ryland	should be filad ind Mantal Hygid s marked other umatic evant, II.	To Be (17. Father's Name (First, Middle, Last) Joseph Teiberi 19a. Informant's Name/Relationship (7		10h Mailie	ag Addrona (Stron	Mary M	me (First, Middle, atukait	is		0.41)
Baltimore, Ma	parmit. Pagas 1 and 2 si Dapartmant of Haatth an Important: If item 27 is r any injury or other traur		Lillian Taber — 20a. Method of Disposition 1 Burial 2 Cremation 3 Control 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Sister Removal from State MC	Place of Dispo cemetery, crep OST HO. Rede	Kirkwo sition (Name of patory or other pla Ly emer C Name and Addr	em 07/	Baltin Date 13/05	nore, M 20c. Location - Baltim	iaryl City or Tov	and 2120
8760,	whysician and hysician and hysician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or construction of the construction	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	ath. Do not ent	er the mode of dy	ng, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between Onset and Death White Market
.O. Box 68	law raquiras that tha daath certificata ba axacuted as baan signad by the attanding physician and 1.2 should ba datached for usa as tha burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 15 No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnance Other (specify)	zy		23d. Dat	te of deliver	ry Day Year
ords, P.	v raquiras that baan signad b should ba data	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.		obacco use contr	nbute to the	e cause of death?
ital Record	Tha ata h paga	Completed						24a. Was autop perfo 1 🗆 Yes	rmed?	prior to com death?	osy findings available apletion of cause of
Division of Vit	<u>S</u> <u>S</u> <u>S</u>	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2	Hospital: 1 pnpatient 2 28a. Dite of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing F	ath Check onl o dome 5 Residence 128d. Describe h)
Divis		27. Manner of Death 1 Gratural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2 No 28e. Place of Injury - At home, larm, street, lactory, office							Street and Numb vn, State)		
	To the Hospital or A within 24 hours after To the Funeral Dire completaly filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Examonal Medical Exam	rsician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death	occurred at the tivestigation, in my	opinion, death occu	urred at the time,	cause(s) and ma date and place, a 29d. Date signed	and due to	the cause(s)
	1313		Harman	A. Buss	4 w	D	40749	4	July	10,	ZOUS
ľ	Sta Registr		31. Date filed (Month, Day, Year)	ompleted dause of seath (It	em 23a) (Type, Hed nature	Zal Cul	Hey "	501 St Bald	Some,	U.Y	pce) 21202

			1- State of Maryland / Department Certificate		I Hygiene		
	Physici /Medio Examin	al		Mor own, or Location of Death	of Death Day	County of Death	Trine growth 6
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months I	Year If Under 24 Hrs. 8. Date Days Hours Min. Nov.	e of Birth	9. Birthpl 17 Ohio	ace (State or Foreign try)
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10c Citi		Od. Inside City Limits 1 Yes 2 No
	h with	ai Dir		20905		zen of What Coun .ted Stat	•
336	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, Ite Modical Examinant invalible molling at a injury or other traumatic event, Ite Modical Examinant.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 No WW II, If Yes, Specify 1 Yes Give Year or Dates: Korea	nt of Hispanic Origin? (Specify Yes y Cuban, Mexican, Puerto Rican, e No <i>Specify:</i>		14. Race - America Black, White, & Specify: whi	etc.
21215-0036	d within 72 ho glene. ar than "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 10 16a. Decedent's Usual (Give kind of work life. DO NOT use Manager	done during most of working		nd of Business/Ind	
and	be filed ntal Hygis ed other	Be	17. Father's Name (First, Middle, Last) Walter Danowski	18. Mother's Name (First, Julia Nosa		Sumame)	
Maryland	2 should be and Ment is marked aumatic	ဂ္		Street and Number or Rural Route		Town, State, Zip	Code)
	and 2 ealth a n 27 is		Marguerite Danowski, Wife 14504 Jayst	tone Drive, Silv			20905
altimore,	permit. Pages 1 and 2 Department of Health s Important: if Item 27 ti any injury or other tra ance.		20a. Method of Disposition 1	onal Cemetery	Arli	ngton, V	
Bal	Departi Departi Import any ir			Address of Facility Sky Funeral Home roll St., NW, Wa		n. DC 2	0012
8760, <	death certificate be executed Water and be executed e attending physician and and dor use as the burial-transit	icai Examiner	23a. Parf.1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	1 (1 (atory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	ne death certif the attending thed for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	, , , , , , , , , , , , , , , , , , , ,	2	23d. Date of delive Month	ry Day Year
	sign sign	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I. 236	e. Did tobacco u:	se contribute to th	5 /5
of Vital Records,	The ate ha	Completed			a. Was an autopsy performed? Yes 2 14 No	death?	osy findings available inpletion of cause of
Vit	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death (Check Other: 4 Nursing Home 5		COther (Care)	
ion of	Attending Phy r death. ector: After this st the funeral c	ertification; T		4 Notice of	scribe how injury		9
Division	al or Attends after death	Sertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)		ation (Street and or Town, State)	d Number or Rurai)	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due my opinion, death occurred at the	to the cause(s) e time, date and	and manner as sta place, and due to	ated. the cause(s)
	To the within 2	Me		License number		e signed (Month, L	Day, Year)
)	ابدي			42033	7/	9/05	
	1041		30. Name and a dress of person and comple cause of death (Item 23a) (Type, Print)	harburg Martin	Portil	30 → ≯ D.	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,			

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State	State of	f Marylan		rtment tificate			and Me	ental Hy	giene	2005	22567
		Registrar 1. Decedent's Name (First, Middle, L	ast)			imodic	01 2	Calif	1	2. Date of De	ath		3. Time of Death
Physicia /Medica		Ray J. Frazier								Month July 8	Day 3. 20	Year	5:25A M
Examine		la. Facility Name (If not institution, g	ive street and nun	nber)		4b. City, T	own, or	Location of	of Death			County of Dea	
		1709 Henry Road				Rock						lontgom	
Funeral		,	Sex 1MM 2□F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		If Under Hours	24 Hrs. 8 Min.	B. Date of Bir (Month, Da	th y, Year)	9. Bir	thplace (State or Foreign ountry)
Director	- 1	218-24-7079 Usual Residence of Decedent		75	115.					Sept.	18,_	1929 Vi	rginia
yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Mar iffed	į.	Maryland Montgo	nery	Roo	ckvill	e							1 X Yes 2 ☐ No
ith the Marylan or 28a-f show	Funeral Director	10e. Street and Number				10f. Zip (Code				10g. Citi	zen of What C	ountry?
ath w 238	<u></u>	1709 Henry Road				2085						ted Sta	
ltems	nue	11. Marital Status	Armed Fo		S. 13. V	Vas Decede f Yes, specif	ent of His fy Cubar	spanic Ori n, Mexicar	gin? (Spec 1, Puerto R	ify Yes or No ican, etc.))-	 Race - Am Black, Whi 	
be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I're Madical Externing must be natified at	S	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	е	1	☐ Yes 2	X No	Specify:				Specify:	hite
2 hou atura		15. Decedent's	Education		16a. Deced	ent's Usual	Occupa	tion			16b. Ki	nd of Business	
8	ble	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1	-4or 5+)	(Give lite. L	kind of work OO NOT use	(done d e retired)	uring mos	t of working	7	Mon	tgomery	County
ed wij	Completed	4			Bui	lding						lic Sch	nools
tatal High od out	e E	17. Father's Name (First, Middle, La.	,					18. Mothe	er's Name	First, Middle	, Maiden	Sumame)	
Id yidiild KIKI 3-0000 2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked other than "natural", or Items 23a aumatic event, Ira Wadcal Exminer must to	<u> </u>	Clifford Frazie: 19a. Informant's Name/Relationship			10b Mailia	- Add	(Ct		a Si		0:	. T Ct	71-0-4-1
Manufacture traur		Ann L. Frazier/										r Town, State,	
TC, IV		20a. Method of Disposition			lace of Dispo	sition (Name	e of		Da			cation - City or	20851 r Town, State
t. Pages tment of I tant: If Its		1 🕅 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec		State Par	emetery, cren rklawn Pa	Memor	rial	1 -	July 1 2005	11,	Pool	kwi 11a	Maryland
그 원원 중 .	-	21. Signature of Funeral Service Lo			22	Name and	Addres	s of Facilit	v Roh	ert A.	Diim	phron I	Junowal Home
Depariming Department of the State of the St		1360/	Lung	. моово	03 K	ockvi ockvi	Lie,	Inc. Mary	300 land	W2585	0228	somery 55	Avenue
45.43		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ly one cause on e	used the death ach line.	n. Do not ente	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Lur	ng Cance	er								Onset and Death 3 Years
/Medical Examiner	1	resulting in death)	Due to (or as a consequ	uence of):								
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience of):								
insit	Examiner	Cause (Disease or injury	51010		30.700 077.								1
be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):								
o ys	ca		d										
ortifica ing ph	Physician/Medi	IF FEMALE:											
ath cer ath cer or use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna irth 2 Fetal	death 3	Ectopic pre					1	23d. Date of de Month	olivery Day Year
the de	ysic	1 Yes 2 No	4∐Pregn 9□Unkno	ant at time of de own	eath 5	Other (spe	icify)						,
es that the death certific igned by the attending plot detached for use as 1		Part II. Other significant conditions	contributing to de	eath but not resi	ulting in the u	nderlying ca	use give	n in Part I	,	23e. Did 1	obacco u	se contribute (to the cause of death?
The law requires that the death certific the has been signed by the attending page 2 should be detached for use as it	od by									1 ₹	Yes 21	□No 3□F	robably 4 Unknown
w require	ompieted									24a. Was	an	24b. Were a	utopsy findings available
The la										auto perfo	ormed?	prior to death? 1 \(\sum \) Ye	completion of cause of s 2 \sum No
vical nec	De C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only		1,510	3 20110
Physic This ce	0	1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatien		-	4 1110	ırsing Hom	e 5 ∑ Resi	dence	6 □Other (Spe	ecify)
ling P	0	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury		c. Injury Work			Bd. Describe	how injur	y occurred	
Attending or death. ector: Afte by the fune	ertification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be on Disease	of Injury - At ho	me form etr	M factory		/es 2□		Rf Location /	Street an	d Number or F	Rural Route Number.
after Direction	ert	4 Homicide determine	buildi	ng, etc. (Specify	y)	oot, lactory,	OHICE			City or To	wn, State)	oral rioute Number,
spita hours ineral y filled	<u>ه</u>	29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, death	occurred a	t the tim	e, date an	d place, ar	nd due to the	cause(s)	and manner a	s stated.
	edical	(Check only 2 Medical Ex	aminer: On the ba	asis of examina ner stated.	tion and/or in	estigation,	in my op	inion, dea	th occurred	d at the time,	date and	place, and du	e to the cause(s)
To t To t	2	29b. Signature and title of certifier	J w	D		29c.	License	number			29d. Dat	e signed (Mon	ith, Day, Year)
17		1000	1				296	75			Ju]	Ly 8, 2	005
14		30. Name and address of person wh											
Stat	•	Ralph V. Boccia 31. Date filed (Month, Day, Year)	a, M.D. ₫ 32. A	6420 Ro	ckleds	ge Dri	ve,	#410	Ο, Βε	thesd	a, Ma	aryland	20817-7847
Registra		JUL 1 1 2005	Elever 4	egistrar's Signa	Bosel								

			For	State	of Marylan				lealth a Death	and M	ental H				
			Registrar 1. Decedent's Name (First, Middle, La	ist)		Cer	uncai	e or L	_eain		2. Date of D	Reg. No	2005	22568	
	Physicia		Mary					Month July	Da	y Year 005	1:15 PM				
	/Medic Examin		4a. Facility Name (If not institution, given	4b. City,	Town, or	Location of	of Death	July		. County of Death	1.13 1				
			12812 Middleval	e Lane			Sil	ver S	Sprin	g		1	Montgome:		
	Funeral		·	Sex 1 □ M 2 💢 F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of B	irth Day, Year)	9. Birth	olace (State or Foreign ntry)	
Ł	Director	}	238-22-3598 Usual Residence of Decedent		89	Yrs.					May 9	, 191	l6 Nort	h Carolina	
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. inside City Limits	
	a-f sh	tor	Maryland Montgon	nery	Si	lver S	prin	3						1 ☐ Yes 2X No	
	ith the	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What Cou	ntry?	
	ath w	ral	12812 Middlevale					2090					nited Sta		
	ter de Items ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	cedent Ever in U. orces? 2 🔯 No	S. 13. \	Was Dece f Yes, spe	dent of Hi cify Cuba	ispanic Origin, Mexican	gin? (Spe 1, Puerto	cify Yes or N Rican, etc.)	10-	 Race - Ameri Black, White, 		
93 9	urs af	by	3 ₩ Widowed 4 Divorced	If Yes, G Year or I	ive T		1 🗌 Yes	2 ⊠ No	Specify:				Specify: White		
9500-612	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23a or 28a-f show ant, Ite Macalcal Examiner must be mailfied at	Completed	15. Decedent's E (Specify only highest gr		1	16a. Deced	dent's Usu	al Occupa	ation	t of worki	20	16b. K	(ind of Business/Ir	ndustry	
7	ithin 7	npie	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.			during most	COF WORK	19				
7	e filed w Il Hygier other th	Co	17. Father's Name (First, Middle, Lasi	2			Mar	ager			(First, Midd		artment	Complex	
and	d be filed intal Hyg ed other	Be	Gus Russos	,							ussos	ie, iviaider	i Sumame)		
Maryland	should nd Me mark matic	ဌ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a				ber. City	or Town, State, Zij	c Code)	
2	nd 2 saith ar 27 is rtrau		Nicholas G. Poul		n		-							land 20906	
ē,	as 1 a of Hea Item		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition /Na	ne of		uly C			ocation - City or To	own, State	
Ĕ	Page nent ant: If ury o		1 XBurial 2 □ Cremation 3 [14 □ Donation 5 □ Other (Speci		1 State	kwood	-		1		005	No	Raleigh orth Caro	l, lina	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event <u>once</u> .		21. Signature of Funeral Service Lice	nstee 1		D ₄	Name ar	A Addres	ss of Facilit	y 7 Fune	ral Hon	ne/Roc	kville, In	rc.	
	00 = e d		Mulling	MAMO	M014	20 30	00 Wes	t Mon	tgomer	y Ave	nue, Ro	ckvill	le, Marylar	nd 20850-2805	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on	each fine.			ie ot ctyln	g, such as	cardiac c	r respiratory	arrest,		Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		zheimer		ease							Years	
	Examiner		Due to (or as a consequence of):												
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury												
	acuted nd transi	Examiner	that initiated events	c											
o,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to	(or as a consequ	uence of):									
6876U	physicate to physical	ledicai	•	d							···· ·	-			
BOX	certif nding use a:	√Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna								23d. Date of deliv	erv	
	death e atte	Physician/M	in the past 12 months?	4⊡Preg	birth 2 Tetal mant at time of de]Ectopic p] Other <i>(s</i> ;						Month	Day Year	
J.	at the de by the a stached	hys	9 🗆 Unknown	9∐ Unki											
	res that igned b	by	Part fl. Other significant conditions	contributing to	death but not resu	ulting in the u	nderlying (ause give	en in Part I.			131		he cause of death?	
Vital Records,	w require been si should b	Completed									1 -	Yes 2	MNO 3 Pro	bably 4 Unknown	
Ş	elaw hasb je2s	mpi										is an opsy formed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of	
a	(b) C		OF What are referred to me first	T							1 Yes	2 & No		2 No	
	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2	EB/Outpatier	* 3 1 10	Othe	0.51		(Check onl)		6 ☐ Other (Speci	6.1	
10	g Physer this eral dif	⊢	27. Manner of Death	28a. Date		28b. Time of		28c. Injury Work			28d. Describ			(19)	
0	Attending F death. ctor: After y the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	on	ini, Day Tear,	Injury	М		Yes 2 ☐	No					
Division	Hospital or Attending Physician: 14 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	Certification;	3 Suicide 6 Could not determined	28e. Plac	e of Injury - At ho ding, etc. (Specify	ome, farm, str	eet, factor	y, office			28f. Location City or T	(Street a	nd Number or Run e)	al Route Number,	
a	spital or ours afte leral Dir filled in		00- 0	E											
	a Hospital or Atten 24 hours after deatl Funeral Director: etely filled in by the	edical	29a. Certifier 1 X Certifying P (Check only 2 Medical Exe	miner: On the	le best of my kno basis of examina nner stated.	wledge, death tion and/or in	n occurred vestigation	at the tin	ne, date an pinion, dea	id place, i ith occurr	and due to the	e cause(s e, date an	 and manner as a d place, and due t 	stated. o the cause(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	011	11 1		29	c. License	e number			29d. Da	ate signed (Month,	Day, Year)	
	4		> Muchae	0 11/	trodes			MD	15901			J	uly 6, 2	005	
1	3		30. Name and address of person who	completed cau	use of death (Item	1 23a) (Type,	Print)		- 						
-	7		Michael J. Grady	, M.D. 4	201 Catl	nedr <u>a</u> l	Aven	ue, N	I.W.,	#114W	, Wash	ingt	on, D.C.	20016	
	Sta Registr		31. Date filed (Month, Day, Year)	5	Registrar's Signa	erun	W								

	ss dree	.11	1- State Amend Item 1 Registrar	State of Maryla ,19a-b&Unpend	and / Depa I Item &	artment of	f Health and	Mental Hyg G845 7-2]	giene L-05	tas	2250
Ą	Physici		1. Decedent's Name (First, Middle, Las Charles E. Gre	7				2. Date of Dea Month July	O2,	2005 2005	11:14 AM
	/Medio Examir		4a. Facility Name (If not institution, give 707 Concord Drive	street and number)		4b. City, Town	n, or Location of De ville		4c. C	ounty of Death	
	Funeral Director		5. Social Security Number 217-54-2463 Usual Residence of Decedent	7. Age (In yi X M 2□F	rs. last birthday) Yrs.	If Under 1 Ye Months Da			h y, Year) 950	Cour	place (State or Foreign otry) yland
,	Maryland -f ehow	tor	10a. State 10b. County Md Cecil	10c.	City, Town or Le					1	0d. Inside City Limits
	with the a or 28s	Director	10e. Street and Number	•		10f. Zip Cod			-	en of What Cour	ntry?
980	within 72 hours after death with the Maryland ane. then "natural", or Itema 23e or 28e-f ehow Ite Mudical Examine cumit be mulled at	by Funeral	707 Concord DF 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 19		Was Decedent	of Hispanic Origin? Juban, Mexican, Pue	(Specify Yes or No- arto Rican, etc.)	- 14	Race - Americ Black, White,	
21215-0036	71 74 14 14	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th		(Give	dent's Usual Oc kind of work do DO NOT use re Sekeep	ne during most of w tired) ing		VA	of Business/In Health	
Maryland	a la la	ro Be	17. Father's Name (First, Middle, Last) Charles E. Gre	en Sr.				_{ame (First, Middle,} in Holt	Maiden S	umame)	
Mary	s 1 and 2 should t Heelth end Mer Item 27 le marke other traumatic	8	19a informant's Name/Relationship (7	ype, Print)	P ^{9b} O ^{Maili}	Box 325	Bastover	Rural Route Number	City or	Town, State, Zip	Code)
Baltimore,	permit. Pages 1 au Depertment of Hee Important: if Item eny Injury or othe ance.		20a. Method of Disposition Durial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature Fineral Specifications)	Removal from State	cemetery, cre ouden		Place) C M	lylie F/	Balt H of		Md more'to.
	Physician /Medical Examiner		232 Page Enter the disease, or come speck, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Hypertensiv	ye cardi	ter the mode of	dying, such as cardi			OWII, P	Approximate Interval Between Onset and Death
68760,	the death certificate be executed y the ettending physicien and tched for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons d.							
.O. Box	at the death certific by the ettending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prec 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3[□Ectopic pregna □ Other (specify			23	ld. Date of delive Month	ery Day Year
rds, P	luires the signed old be de	þ	Part II. Other significant conditions or	entributing to death but not r	nbuting to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to t	
al Records,	⊕ <u>∩</u>	Completed						24a. Was autop perfor	rmed?	24b. Were auto prior to co- death? 1 Yes	psy findings available impletion of cause of
Vital	Physiclan: this certific ral director,	To Be	25. Was case referred to medical examiner? 1X Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	0:1	eath Check only on Home 5 Resid		(C)Other (Specif	o COLDIE
sion of	D e		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. l	njury at Work?	28d. Describe h			W SCENE
Division	tal or Attendir rs after death, al Director: Al ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, st ecify)	reet, factory, offi	се	28f. Location (S City or Tow	Street and vn, State)	Number or Rura	I Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat ination and/or in	h occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the courred at the time, of	cause(s) a date and p	nd manner as si place, and due to	tated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier Josha	Ireef M	D		ense number OCME			signed (Month, 03, 200	, . ,
-		J		completed caus of death (It	tem 23a) (Type,	111 Pe	enn Stree	t Baltim	ore,	Marylar	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32 Pagistrar's Sig	gnature	(- N .					

amend item#10e,16b, perfn, G845, 7/11/05 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3GA 2005 WIS /Medical 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Poholilitation Extended care N/A 6. Sex 1 X M 2 ☐ F f Under 1 Year | if Under 24 i Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Yrs. Director 100-14-7077 85 APR.10,1920 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show the Medical Examiner must be notified at MD N/A BALTIMORE 1 ¥ Yes 2 □ No Director or 28e-f 10e. Street and Number Washingtonyille
1113 WASHINIONVILLE 10f. Zip Code 10g. Citizen of What Country? or Items 23a DRIVE 21210 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Maintenance 4 AIRCRAFT MECHANIC A<u>IRCRAFT</u> <u>MAINTANCE</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked o ABRAHAM GROSSMAN HELEN BUTT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEIL J. GROSSMAN / SON f Health i 1113 WASHINGTONVILLE DRIVE - BALTIMORE, MD 21210 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department of Importent: If any injury or BETH DAVID 07/08/2005 ELMONT, NY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate cancer Physician monto /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit Pasal cell that initiated events resulting in death) Last Box 68760. Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 Tyes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 2 No 1 Yes 2 No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient dire P 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After the Hospitel or Attending Natural 2 Accider 5 Pending 1 Tes 2 🗆 No Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Augustin Chyu mx 30. Name and and ess of person who contribeted cause of death (Item 23a) (Type, Print) AUGUSTIN CHYU. M.D. 3900 Lock Ravon Blvd. Baltimore, MD JUL 1 1 2005 State Registrar

amend item#19b, perfff, G845, 7/11/05 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SOL GLICKER JULY 5, 2005 РМ /Medical 1:43 4a. Fecility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deeth 10449 STERNWHEEL PLACE COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth AWG. 19, 1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 1 M 2 □ F 098-30-5669 Director 76 NY Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at MD HOWARD 1 Yes 2 No COLUMBIA Direct 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? 10449 STERNWHEEL PLACE 21044 238 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If #es, Give Year or Dates: ARMY 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, et 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 □ Yes 2 No WHITE þ 3 Widowed 4 Divorced "natural" Completed other than "naturent vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Elementary/Secondary (0-12) CHEMIST SCIENCE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) should be JACOB GLICKER FRIEDA (UNOBTAINABLE) ဥ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number of Ryral Route Number, City of Town State, Zip Code)

449 STERNWHEEL PLACE - COLUMBIA, MD 21044 f Health LAURA GLICKER / DAUGHTER other 20b. Place of Disposition (Name of cornetery, crematory or other place) 20c. Location - City or Town, State ō Department of Important: If any injury or once. BALTIMORE HEBREW 07/08/2005 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Idmana LIKAMO 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Iding physicien and use as the burial-transit be executed Due to (or as a consequence of) Box 68760, Physician/Medical use as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery atter 1 Live birth ō 2 Fetal death 3 Ectopic pregnancy 4☐ Pregnant at time of death Month Day Year ed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by d be detact Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₹ No page 2 autopsy performed? 1 🗌 Yes 2 No Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient this 3 DOA Alter thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 Natural death investigation the 2 Accident 1 Yes 2 No To the Funeral Diractor: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide hours after 9 Hospitel 145 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10 30. Name and address of person who completed ause of death (Item 23a) (Type, Print Patyxent PRWY, Columbia Lee Edward

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 1 2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:12 AM AE /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE If Under 1 Year | If Under 24 Hrs. KERNAN HIUSPITAL n/a Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2√2 F Yrs. 217-80-4380 Director 1/22/64 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Cecil Conowingo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 174 Johnson Rd. 21918 USA or Items 23a by Funerai Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Receptionist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ann Rae Beere Frank Kwiatkoski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Glass / Husband 174 Johnson Rd. Conowingo, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If Ite any injury or of once. 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/05 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Md. 21. Signature of Funeral Service Licensee ሺልሮኒሚኒያያያዩቸና። Funeral Home P.A. 1201 Dundalk Ave. Baltimore, Md. astro 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List party one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition AR DISU ASCULAR **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** MASSIUE BLOUD Sequentially list conditions. Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Spual STE.

Due to (or as a consequence of): STENOSIS P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 MNo should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? page 2 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) iner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No Inpatient 2 ☐ FR/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC SHUMADIMA KERNIN HOS ITAL 2200 HERVANDA BACTIMORE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Madison N. Hahn 05-04569 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland	/ Department of Health	and Mental Hygien

		_	For State Registrar	State of Ma	aryland /	-	rtment of H tificate of L				Reg. N		22573	
	Physici		1. Decedent's Name (First, Middle, La. MADISON NICHOLA							2. Date of De Month July		2005	11:10 A ^M	
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town, or		of Death			c. County of Death	111.10 11	
			8528 Storch Wood: 5. Social Security Number 6. S		e (In yrs. last i	hirthday)	Savage	If Under	r 24 Hrs.	8. Date of Bi	rth	Howard 9. Birth	place /State or Foreign	
	Funeral Director			₩ 2□F	83	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, Di Jan. 3]	ау, Үөа . , 1	Year) 9. Birthplace (State or Foreign Country) 1922 Washington, DC		
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation						10d. Inside City Limits	
	Mary a-f eh	tor	MD Howard		Savag	je							1 ∏Yes 2 ☐ No	
	or 28	Director	10e. Street and Number	Davis 113	70		10f. Zip Code				-	Citizen of What Cou	ntry?	
	eath w		8528 Storch Woods	Drive #1		13. V	20763		rigin? (Sp	ecify Yes or N		S.A.	can Indian.	
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Iteme 23e or 28e-f ehow enty injury or other traumatic event, the Medical Expirit per must be notified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XXes 2 □ N If Yes, Give Year or Dates:		_	Vas Decedent of H f Yes, specify Cuba □ Yes 2XXNo	n, Mexica Specify		Rican, etc.)		Black, White,		
ς Ο	72 ho	eted	15. Decedent's En (Specify only highest gra	ducation ade completed)	16	(Give	lent's Usual Occup- kind of work done	during mo:	st of work	ing	16b.	Kind of Business/In	ndustry	
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5 1 year	i+)	Inve	00 NOT use retired Stor	1)			S	elf-Emplo	oved	
מ סר	be filed tal Hygir d other event, t	Be C	17. Father's Name (First, Middle, Last,					18. Moth	er's Name	First, Middle	1	-	4	
ylai	should band marked	Tof	Nicholas Hahn						th K					
Maryland 21215-0036	d 2 sh th and th and 7 le m traum		19a. Informant's Name/Relationship (Sylvia Crutchfile				g Address <i>(Street)</i> Madison S andria, N			al Route Numb partmer 22314	per, City 1t I	or Town, State, Zij 902	o Code)	
	s 1 and t Health Item 27 other tr		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place	1		ZZJI4 Date	20c.	Location - City or T	own, State	
E O	Peges nent of I ant: If It ury or o		1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1		del Crema		7/	9/2005	0	denton, M	Maryland	
Baltimore,	permit. DepartmImporta eny inju		21. Signature of Floured Service Licen		0220		onserration					######################################		
	403.4		23a. Part1. Enter the disease, ir com	plications that caused	0770 I the death. D		13 'Talbot er the mode of dyin					Maryland	20 / U7 Approximate	
) }	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as	a consequence		wound -	ta H	ead	14 - 4-4 - 15-4			Interval Between Onset and Death	
68760,	fficate be executed g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as										
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o	Physic rthis or ral din	-: To	Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	nt 2 EPV	Outpatien b. Time of		4 🗆 1		me 5 Res			_{fy)} at scene	
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	Hospital 24 hours e Funeral (letely filled	edical (29a. Certifier 1 Certifying PI (Check only one) 2 Medical Example 1	nysicien: To the best miner: On the basis of and manner sta	fexamination	dge, death and/or inv	n occurred at the fin vestigation, in my o	ne, date a pinion, de	nd place, ath occur	and due to the	cause	(s) and manner as	stated. to the cause(s)	
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6	A		30. Name and address of person who			а) (Туре,	Print) 111 Per	nn St	treet	Balt	imor	e, Maryla	and 21201	
	Sta	te	31. Date filed (Month, Day, Year)	1. 1171, W 32. Flegist	ar's Signature)						,		
30	Regist		JUL 1	1 2005	Name	H	ford .							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year **Physician** Josephine Μ. Hawkins 6CT 2005 6-25AM 4b. City, Town, or Location of Death /Medical 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Lorien Nursing Home <u>Columbia</u> Howard If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) If Undar 24 Hrs 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2□ F Yrs. 212-18-0576 June 18, Director Wyoming Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No MD Funeral Director Carrol1 Sykesville 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 7538 Braemar Court 21784 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Navar Married 2 Married 1 ☐ Yes 2 X No Specify Be Completed by Specify: White 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Helms ပ Sarah Lafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Ms. Kelly Hawkins (Daughter) 7538 Braemar Court Sykesville, MD 21784 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 7/9/2005 Sykesville, MD 21. Signeture of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that and ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) END STAGE COPD monus Examiner Physician/Medical Examiner monto CONGESTIVE or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) this certificate has been signed by the erel director, page 2 should be deteched Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hrknown δ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? † ☐ Yas 2 la No 1 ☐ Yes 2 ☐ No After this certific funerel director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide edicai 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29c. License numbe 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier Sprohe MO JULY 600 2005 20053150 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SUITEIIO ROAD SHALEUNMALA COUPTA 9650 SANTIAGO COWNBIA 21045 31. Dete filed (Month, Day, Yeer) State Registrar

DHMH 17 Rev 1/2001

Registrar

LORRAINE

HENDRICKSON,

32. Registrar's Signature

ERNESTINE WRIGHT, M.D.

2005

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY ROAD

TIMONIUM

MD

21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Show-Pin Ho 8, July 2005 8:05 P .M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7500 Woodmont Avenue #321 Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 24, 1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months 503-74-1668 Director 80 China Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Itams 23a or 28a-f show the Medical Examinar must be notified at Maryland Montgomery Bethesda Director 1 ☐Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7500 Woodmont Avenue #321 20814 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 X No Specify: \$ 3 Widowed 4 N Divorced Year or Dates: 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it and 2 should be fill Health and Mental H Be Rong-Guang Ho Zhi-Dong Qin ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Yung-Lung Ho/ Son 9300 Wildoak Drive, Bethesda, Maryland 20814 othar t 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial ō permit. Page Department o Important: If any injury or once. July 10 Rockville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Park 2005 22. Name and Address of Facility Robert A. 21. Signature of Funeral Service License Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 75 Bethesda, Maryland 20814-3501 557 Wisconsin Avenue M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events <u>Coronary Artery Disease</u> Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit Chronic Renal Failure resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the as attending IF FEMALE: esn : 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? res 2X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) a Certification: 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 3 🗀 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide after 24 hours a 1X Certifying Physiciam. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 Tot 29b. Signature of certified 29c. License number 2 29d. Date signed (Month, Day, Year) D28437 July 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven A. Burka, M.D. 5530 Wisconsin Avenue, #914, Chevy Chase, Maryland 20815 32. Registrar's Signature 31. Date filed (Month, Pay, Year) JUL 1 1 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Dorothy Hood July 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jacobs Well Assisted Living Bel Air Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr -4,1924 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F 219-18-2392 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 28a-f show rthan "naturel", or items 23a or 28a-f shov the Madical Examiner pust be notified at Director Md. Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1236 Chateau Green Court 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Yes. Give 3 XWidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than Home Maker Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Palasik Stella Pakulski George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Jones (daughter) 1236 Chateau Green Court BelAir, Md 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem 7/9/05 Baltimore, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License once. Robert 2525, Fleet Street Baltimore, Md wa 23a. Part1. Enter the disease, or complicative a that caused the death. Do not enter the note of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one is use on each line. Immediate Cause (Final Physician /Medical resulting in death) to (or as a consequence of **Examiner** osclerotic Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ peq Completed should peen 24a. Was an has autopsy certificate 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 일 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗍 Suicide 6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Approximate Interval Between Opset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Assisted Living 6 (X)Other (Specify) 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. Ligense number 29d. Date signed (Month, Day, Year) July 7, 2005

Year

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Maryland

White

To the Hospitel or Attending Physicien: Director: After in by within 24 hours a To the Funeral C Medical

> State Registrar

4 Homicide

29b. Signature and title o

1

29a. Certifier

CIKN 31. Date filed (Month, Day,

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and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print),

		1	- For Amend Item (Registrar	State of per me	G845 7	nd / Depa -12-05 Cer	artmen tas rtificat	t of H e <i>of L</i>	ealth a Death	ınd M	ental Hyg	ene g. No.2	105	225	70
	siciar	1	. Decedent's Name (First, Middle, Caprilla Fuller CAPRILLA R.	Jackson							2. Date of Death Month June	Day 26	2005 2005	3:30	Defath O
	edica imine		a. Facility Name (If not institution, 1347 Pentridge	give street and nu			1	Town, or ltima	Location o	f Death			nty of Death N/A		
Fune Direc			215 17 7098	Sex 1□M 2□√F	7. Age (In yrs 3 1	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, JUN - 26	. 1974	9. Birthi Cou MA	place (State of htry) RYLAN	r Foreign D
Aaryland f show	18 74	1	Jsual Residence of Decedent Oa. State 10b. County MD . N/A		10c. C	BALTI								0d. Inside Ci 1∕∑Yes	-
with the h	Direction of	2 -	0e. Street and Number	TE DOAD			10f. Zip	Code 1239	<u> </u>		10		of What Cou	•	
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital hygiene. In other than "natural", or itema 23e or 28e-f show		by ruileia	1. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dec Armed F	cedent Ever in orces?		Was Deced	dent of Hi	spanic Ori	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. R	lace - Amenilack, White,	can Indian, etc.	
21215-0036 ad within 72 hours aff rgiene. er than "natural", or	Tip Medical C	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed, College	(1-4or 5+)	16a. Dece (Give	dent's Usua kind of wo RRVKT us	rk done a	during mosi	t of workii	na l		Business/In	,	
Maryland 2 Id 2 should be filed Ith and Mental Hygi	Tatic event,	0 0	12TH 7. Father's Name (First, Middle, L. THEODORE ANT)	HONY FU	LLER	10h 14a/iii		(Strant a	SHA	RON	(First, Middle, Market R. HY) I Route Number,	NSON		Cadal	
tem:	ry or other treumatic		19a. Informant's Name/Relationshi AARON JACKSOI 20a. Method of Disposition ★□ Burial 2 □ Cremation (Special Special Specia	N (HUSB	20b.		7 pe:	ntri	dge	roa	d BAL	TIMOF	RE, MD		¥9 AND
Baltimol permit. Pages Department of Importent: If i	any inju		21. Signature of Funeral Service L	offen		4	517	PARE	(_HEJ	GHT	UNERAL S AVEN	JE_BA			93
8760, Wedi Exami Exami physician and	ner	aminer	23a. Part1. Enter the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	caused the de- each line. Ut ple (or as a conse	dunsv (ite concupy):				cardiac o	respiratory arre	ist,		Approximat Interval Bet Onset and I	ween
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rds, P. quires that the signed by	ep eq	<u>`</u>	Part II. Dther significant condition	s contributing to	death but not re	esulting in the u	nderlying o	ause give	en in Part I.		23e. Did tob			he cause of dopably 4 🗆	
	م ر	completed	25. Was case referred to medical						OC Disease	of Dooth		ned?	prior to co death?	psy findings mpletion of c	
Vision of Attending Phy er death.	by the funeral direct	ermication; to b	25. Was case releared to medical examiner? 1	28a. Date (Mo	of Injury onth, Day Year) 2005 se of Injury - At ding, etc. (Spec	ER/Outpatier 28b. Time of Injury 3:20 home, farm, st. cify)	A M	28c. Injun Work 1 [] '	er: 4 □ Nu yat k? Yes 2 🌠	rsing Hor	me 5 Reside 28d. Describe ha Subject 28d. Location (State of Town 1347 Pen	w injury occurrent and Nur, State)	mber or Run	al Route Num	ber.
Hospita 4 hours Funeral	6	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the xaminer: On the and ma	e best of my k	nowledge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the ca	use(s) and	manner as s	tated.	,
To the within 2	dwoo	Me	29b. Signature and title of certifier Joshol	Me	e M	vD	C	c. License CME	e number				ned <i>(Month,</i>		
			Taska Z Gre	no completed cau	120		111	Pen	n Str	eet	Baltimo	ore, M	ary1a	nd 212	01
Re	State gistra	-	31. Date filed (Month, Day, Year) JUL 1 1 20	05 Sen	Hegistrar's Sig	nature	a)								A _k e

Lloyd M. Jennings CPM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK 1- State Amend Item 5&8&Unpend Item 23 & Figure 1 684 7 7-28-05 tas Registrar 05-04452 1. Decedent's Name (First, Middle, Last) 2. Date of Death O1, Month July Physician 2005 20:08 /Medical 4a. Fecility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 2354 Usual Residence of Decedent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 12-21-1963 Birthplace (State or Foreign Country) 1 M 2 □ F Director Maryland 10a. State 10h. County 10c. City, Town or Location 289-f ahow 10d. Inside City Limits treumatic event, the Medical Examiner noust be notified at Director 1 Yes 2 No the 10e. Street and Number 10g. Citizen of What Country? ö 23a Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. I Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook ESTURANT 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mental 1 Is marked ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Father 303 LORENING Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of P Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate raise. Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical as the signed by the attending d be detached for use as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year P.O. I 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by been si 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 1 Yes 2 □ No 24a. Was an page 2 s has autopsy performed? this certificate of Vital 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: ٩ 1 XYes 2 ☐ No 2 €R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Hamela E. Southall, mD

31. Date filed (Month, Day, Year)

32 Registrar's Signature

(Month, Day, Year)

JUL 1 1 2005

32 degistrar's

egistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

OCME

111 Penn Street

July 02, 2005

Baltimore, Maryland 21201

			For State Registrar	State of Marylan		artment of H				05	22580
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of t	Jean	2. Date of De	-45		3. Time of Death
	Physicia /Medic		John Edward Jo					Month SVV	Day 71	2005	78 M
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Dear timore C		4c. Count	ty ol Death	
	Funeral		4102 Greenway 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		th V Year)	1	ace (State or Foreign
	Director		216-20-7470 1 Nusual Residence of Decedent	w 2□F 81	Yrs.	Months Days	Hours Min	8. Date of Bird (Month, Da May 20,	1924	New	York
	yland 10W		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	se Mar 8a-f st	ctor	MD N/A	Bal.	timore	_ _T					1 X Yes 2 No
	with the la or 2	Funeral Director	10e. Street and Number 4102 Greenway			10f. Zip Code 21218			10g. Citizen of	What Count	ry?
	death	nera		2. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No		ice - America	
36	s after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Nes 2 No If Yes, Give Year or Dates:	i	1 ☐ Yes 2 ᠓ No	Specify:	10 1110411, 010.)	Speci	ifv:	
21215-0036	be ilied within 72 hours after death with the Maryland Ital Hygiene. od other then "natural", or Items 23a or 28a-f show event, the Modical Exemities outst be notified at	ted k	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occupa	ation	arking	16b. Kind of I	Wh1 Business/Ind	
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+) 5+	life.	och Analy)	irking	C+00k	Mandro	.4
d 2	e filed val Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	31	Reseal	Ch Allaly		me (First, Middle,	Stock Maiden Suma		it
ylan	should be nd Mental marked c	To B	John Edward Johnst	on, Sr.			Katharir	ne Smith	Reynol	ds	
Maryland	ges 1 and 2 should t of Health and Men If item 27 is marke or othar traumatic		19a. Informant's Name/Relationship (Type		0230000	ng Address (Street a			TWENTHUMAN	n, State, Zip	Code)
	of Heali item 2 other		Charles A. Dashner 20a. Method of Disposition	20b. P	lace of Dispo	York Roa sition (Name of matory or other place		iun, MD_ Date	21093 20c. Location	- City or To	wn, State
Baltimore,	Page ment o ant: If ury or		1 Burial 2 Cremation 3 Rei `4 Donation 5 Other (Specify)	St.		's Govans		2/05	Baltimo	ore, M	D
Balt	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Fundral Service Could be	1 0		Name and Addres		1 Hama			k Road
			23a. Part 1. Enter the disease, or complici shock, or heart failue. List only one	ations that caused the deat		JCK TOWSO er the mode of dyin				wson,	MD 21204 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			1191 Inf				3	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		,				
	4.	jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				· · · · · · · · · · · · · · · · · · ·		
	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
8760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) cast	Due to (or as a conseq	uence or):						
9	tificate ng phys as the	e	d.			,			7.		
Вох	the death certific y the attending pl iched for use as t	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy			1	ate of deliver	ry Day Year
o.	that the de ed by the a detached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5	Other (specify)					
s, P	es be	by P	Part II. Other significant conditions conti	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	_	A		e cause of death?
Records,	w requir been si should	eted						10'			ably 4 □Unknown
Rec	The age	Completed						24a. Was autor perfo		prior to con death?	psy findings available inpletion of cause of
Vital		Be C	25. Was case referred to medical examiner?					ath (Check only o		103	2,42,110
of \	Phys this ral dii	. To	1 ☐ Yes 2 No Ho	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier		4 Nursing	Home 5 Aesi)
ion	Attending I r death. sctor: After by the funer	atlon	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	of or Attendate death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sta y)	eet, lactory, office		28l. Location (City or To		ber or Rural	Route Number,
	To tha Hospital or At within 24 hours after of To tha Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wledge, deat	h occurred at the tin	ne, date and place	e, and due to the	cause(s) and n	nanner as sta	ated.
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	one)	er: On the basis of examina and manner stated.	ition and/or in						
	To tha within 2 To tha comple	Σ	29b. Signature and title of certifier			29c. Licenso			29d. Date sign	ed (Month, L	Day, Year)
, ^	111		30. Name and address of person who com	npleted cause of death (Item	п 23а) (Туре,	1076°			//8/		1000
2	0 7		agenyelen	en 760			1 Ag	1 Hr-c	, m	212	3.6
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 1 2005	32 Registrar's Signa	ature Los	elain it					
			005 - + 5003	THE TOUR OWN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible) -
State of Maryland / Department of Health and Mental Hygiene	

			For	State of Maryland				lental Hygi	iene		
			State Registrar		Cer	tificate of l	Death		a 1/5 ()	5	22581
	Physicia	an	Decedent's Name (First, Middle, La	ast)				Date of Death Month	Day	Yeer	3. Time of Death
	/Medic		<u>Estelle Jone</u>					الم الم		005	4:00 PM
	Examin	er	4a. Fecility Name (If not institution, give	0 0 1		0	Location of Death		4c. County	of Death	
350	-		Sinai Hospital 5. Social Security Number 6.3	Sex 7. Age (In yrs. 16		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	. Funeral Director			1□M 2DXF 60	Yrs.	Months Days	Hours Min.	(Month, Day, 6 - 17 - 1	1945	Coun	/land
	ਰੂ		Usual Residence of Decedent								
	anylar show		10a. State 10b. County		, Town or Lo	cation				11	0d. Inside City Limits 1 ☐ Yes 2 No
	8e-f	ecto		imore	n/a	Tank and a second					
	with th	Ē	10e. Street and Number	d Dood		10f. Zip Code 2 1 2 (10		og. Citizen of V USA		ntry r
	hours after death with the Maryland lurel; or Items 23s or 28e-f show al Ezatrinet must be notified at	Funeral Director	7307 Campfiel		S. 13. V			ecify Yes or No-		e - Americ	an Indian,
_	riten	F	X X Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No			ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)		k, White,	
	rei', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2□XNo	Specify:		Specify	AME	Prean
2	72 hc 'netu	Completed	15. Decedent's E (Specify only highest gr		16a. Deced	dent's Usual Occup kind of work done	ation during most of work f)	ing	16b. Kind of Bu		· 1
V	within 72 ene. then "nel	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)							ecurity
Z	e filed within al Hygiene. I other then "	ပိ	17. Father's Name (First, Middle, Las	<u>Z</u>	<u> </u>	aims Rev	18. Mother's Name	e (First, Middle, N			ation
and	hental l	o Be	William Jones	7			Viola			-,	
5	s 1 and 2 should be filed within 72 hours after death with the Marylan if Hauth and Mental Hygiene if the marked other then "neturel", or llems 23s or 28e-f show item 27 is marked other then "neturel", or llems 23s or 28e-f show other treumatic event, the Medical Examinating must be notified at	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Run		City or Town,	State, Zip	Code)
M	nd 2		William Jones	/Son	730	7 Campf	ield Roa	d. Pike	svill	e. N	1d 21208
ē,	es 1 a of Hea f item r othe	li	20a. Method of Disposition	20b. Pt	ace of Dispo	sition (Name of matory or other place			20c. Location -		
aitimor	Pages nent of int: if it iry or o		1X Burial 2 ☐ Cremation 3 ('4 ☐ Donation 5 ☐ Other (Spec			Mem.Par		2/05 Ar	rbutus	, Má	iryland
מוב	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funer Service Lice	nsee	92	Name and Addre	ss of Facility Wy 1	ie F/H	P.A. H	f-Ba	1 ¹ 21133 ^{unt}
			222. Part 1. Enter the disease, or cor	mplications that caused the death						,	Approximate
	2000	5	Immediate Cause (Final	10							Interval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ence of):					'	(Day 8
	Examiner			Metastatio		ast Car	ices			- 1	6 Months
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	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ							
8/60,	cate be executed physician and the burial-transit			506 to (or as a consequ	101100 01).						
β	icate phys s the	edicai		d							
XOR	requires that the death certificen signed by the attending I hould be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		_			23d. Da	te of delive	ery
ň	death e atte	icia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		∃Ectopic pregnancy ∃ Other (specify) _			Mo	onth	Day Year
J Ö	t the by th tache	hys	9 Unknown	9□ Unknown							
ŝ	Se 00 00	by P	Part II. Other significant conditions	contributing to death but not resu	ılting in the u	nderlying cause giv	en in Part I.				ne cause of death?
מ	v require been si should t	ted						1 ∐ Ye	s 2 No	3 Prob	pably 4 Gunknown
Hecord	as b	ompleted						24a. Was a autops	v	prior to coi	psy findings available mpletion of cause of
	Tate at	S						perform 1 Yes 2		death? 1 🗌 Yes	2(1No
Vital	Physician: The this certificate ral director, pay	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat		4		
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0	ding Ih. After funer	tion	1 Natural 5 Pending 2 Accident investigate	(Month, Day Year)	Injury	Wor	k? Yes 2 □No		1,	107	
DIVISION	Atten deat ctor: y the	fica	3 Suicide 6 Could not	be 28e. Place of Injury - At ho	me, farm, st	reet, factory, office	-	28f. Location (St.	reet and Numb	per or Rura	al Route Number,
5	after s after all Dire	Certification;	4 Homicide	building, etc. (Specify	')			City or Town	n, State)		
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funera		29a. Certifier 1 Certifying F	Physician: To the best of my known miner: On the basis of examinat	wledge, deat	h occurred at the tir	ne, date and place,	and due to the ca	ause(s) and ma	anner as s'	tated.
	the hin 24 the Find Find Find Find Find Find Find Find	Aedicai	one)	and manner stated.							
	V V V	Σ	29b. Signature and title of certifier			29c. Licens		2	9d. Date signe		
	~ ~			\leq , $\delta \circ$			-000		July	1,2	005
1	1		30. Name and address of person who				- Baltin	1 - 70 00			
	· · Sta	ate	Seth Cohen 31. Date filed (Month) Pay, Year)	32 Registrar's Signa	ture	ورتصل حا	Dalli	ACOI K			
	Regist		AOF 1 1 5	2005 Sinac 32 negistrar's Signa	× de	adis					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	tate of Maryland / De		rtment tificate			ınd Mer		ene 2 0	05	2258	2
	Dhusisi		1. Decedent's Name (First, Middle, Last)							Date of Death Month		Year	3. Time of Dea	
	Physici /Medio		Alda Daisy Shi	pp Kruhm						ון אוני	06	05	1610	М
1	Examin	ıer	4a. Facility Name (If not institution, give stre					Location of	f Death			ty of Death		
			Montgomery General 5. Social Security Number 6. Sex	HOSPITAI 7. Age (In yrs. last birthe	day	U1 If Under 1	ney	If Under 2	24 Hrs a	Data of Righ		tgomer		
	Funeral Director			2F 87 Yr			Days	Hours	Min.	Date of Birth (Month, Day, 1	Ye <i>ar)</i> 1918	Coun	ace (State or Fo. try) MD	reign
	- 13		Usual Residence of Decedent	N 07					ļ 1c	iy 20,	1910		רווט	
	how		10a. State 10b. County	10c. City, Town o	or Loc	cation						11	Od. Inside City Li	
	Ba-1 s	cto	MD Howard	E11	lic	ott C	ity						1 Yes 2 5	XNo
	vith th	Dire	10e. Street and Number			10f. Zip (10		What Coun	try?	
	s 23g	eral	3580 Scheel Drive	Was Decedent Ever in U.S.	17 14		2104		in 2 (Canada	. Vac as No	USA 14 Pa	A ace - Americ	an Indian	
10	itam ineri	Funeral Director		Armed Forces?	lf.	Yes, specif	fy Cubar	n, Mexican,	, Puerto Rica	Yes or No- an, etc.)	Bla	ack, White,	etc.	
980	urs at	þ	3 X Widowed 4 □ Divorced	1 □ Yes 2 1 No If Yes, Give X Year or Dates:	1	☐ Yes 2	X No	Specify:			Speci	‴y∵Whit	e	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or itams 23a or 28a-f show fre Macdeal Examither must be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a. D	Deced	ent's Usual	Occupa	ation	of working	11	6b. Kind of I	Business/Inc	lustry	
7	ithin Jen	nple		College (1-4or 5+)	life. D			luring most	or worning					
	lled w tygien her ti		17. Father's Name (First, Middle, Last)	6		Teac	her	19 Mathar	da Nama (F	irst, Middle, Ma	Educa			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23a or 28a-1 show ther traumatic event, I're Ms. dical Ex. uniter inter the notified at	Be o	Samuel Dorsey	Hobbs				Dai		irginia				
2	2 should and Men is marka aumatic	10	19a. Informant's Name/Relationship (Type,		Mailine	a Address /	(Street a			oute Number,			Code)	-
∑	and 2 sealth ar n 27 is									ville,	•			
ē,	ges 1 and 2 t of Health if item 27 or other tra		20a. Method of Disposition	20b. Place of D	Dispos	sition (Name	e of		Date			- City or To	wn, State	
D = 5 1X Burial 2 Cremation 3 Removal from State 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									005 S	Sykesville, MD				
Baltimore,	permit. Pag Department Important: i any injury o once.	21. Signature of Funeral Service Licensee Lian L. Haugt 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Sykesville, MD 21784 (410)-795-140										A (Box 1400	195)	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the com	ons that caused the death. Do no ause on each line.									Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to (or as a consequence of)										
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9	rtificat ng ph) as th	Physician/Medical	lie een na e											
XOX	eath cartific attending p	an/N	23b. Was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 🗆	Ectopic pre	gnancy					ate of delive	•	
Э. В	e dea the att	slci		4☐Pregnant at time of death 9☐ Unknown		Other (spe					M	lonth	Day Year	
P.0	ras that the de igned by the a be detached t		Part II. Other significant conditions contrib	uting to death but not resulting in t	the un	dorhina on	uso dive	on in Part I		23e Did toba	ICCO USA CO	ntribute to th	e cause of death	2
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Records,	The lav	Completed	Multiple My	closed						autopsy performe	ed?	prior to con death?	npletion of cause	of
Vital		e C	25. Was case referred to medical					26 Place	of Death (C	1 ☐ Yes 24	No	1 Yes	2 No	
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of				28a. Date of Injury (Month, Day Year) 28b. Tin	ne of		c. Injury Work			. Describe how			,	
Ö	ttendir death. ctor: Af / the fu	atlc	1 Natural 5 Pending 2 Accident investigation			М		res 2□N	No					
Division	f or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, stre	et, factory,	office		28f.	Location (Stre City or Town,	et and Num State)	ber or Rura	Route Number,	
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	To the Hospital or At within 24 hours after o To the Funeral Direct completely fillad in by	Aedical	(Check only 2 Medical Examiner:	an: To the best of my knowledge, On the basis of examination and/and manner stated.	death or inv	estigation, i	in my op	oinion, deatl	h occurred a	at the time, dat	e and place	, and due to	the cause(s)	
\	viti To	Σ	29b. Signature and title of certifier	1 10				number			-	ed (Month, I	,	
1			Chillian Illed	elyan			27	190		17	ily 6,	LUC	2083	
6	V		30. Name and address of person who comp	A A		- 1		10+		(Н.	/	1 200	, ~
	° Sta	ate	31. Date filed (Month, Day, Year)	32. Sgistrar's Signature	Ok	andu	1000	, – ,	01	Ney	reary	ian a	2005	3
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** William 05 ENTI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOPKINS BAYNEW/MEDICAL COME Johns If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 217-40-9716 60 03/ MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be nutified at 1 ☐ Yes 2 No Baltimore Dundalk Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21222 USA 621 Aldworth Road Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years 2 years Engineer Telephone Company marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill on of Health and Mental Hint: If Item 27 is marked oth y or other traumatic evening. Be William E. Lentz Sr. Margurette Frazee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 621 Aldworth Road, Dundalk, MD. 21222 Wife Sarah Lentz Pages 1 and 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages Department of H Important: If Its any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) July 8,2005 Baltimore City, MD. Bayview Crematory 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line.

Immediate Cause (Final disease or condition

a. Cerebroizasular Acadent Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of): the attending physician a thed for use as the burial-Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DIABETIS MEllITUS 1 Tes 2 No 3 Probably 4 Unknown as been signal Completed CEREBROURSCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Jas autopsy performed page ATRIAL FIBRILLATION 2LX No 1 Yes funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After t Certification; or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie RES-000 7/7/05 - M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE M.D. JOHNS HOPKINS BAYVIEW HOSPITAL, 4940 EASTERN NE. Arun Venkatesan, MD 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 1 2005

Registrar

Maryland 21215-0036

Baltimore,

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Records,

Division of Vital

Lancaskr Evelyn

			1 - State Registrar		State of M					Death		Reg. N		
	Physici /Medic		Decedent's Name EVE	e (First, Middle, La LYN KATHR		R					2. Date of I Month July		2005	12:06PM
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Ī	Funeral Director		Greater 5. Social Security N 108-20-2379	lumber 6. S	e Medical Sex 7. Ag 1□M XXF 79	ge (In yrs. I	er last birthday) Yrs.	If Und Months	er 1 Year	WSON If Under 24 Hrs Hours Min		Birth Day, Yea 1926	Baltimor 9. Birth Con New	e nplace (State or Foreign untry) York
	and W		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
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	or 28	Funeral Director	10e. Street and Nur						ip Code			10g. 0	Citizen of What Co	untry?
	sath w	eral	8430 Charle	s variey o	OURT APT D 12. Was Decedent	Ever in 11	S 13		21204	lispanic Origin? (9	Specify Ves or I	No.	USA 14. Race - Amer	ican Indian
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	Physician		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition	art failure. List only (Final	nplications that cause one cause on each	line.		ter the m	ode of dyir					Approximate Interval Between Onset and Death
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280		edica			d									
C. BOX	The law requires that the death certificate b tte has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 { 9 ☐ Unknown	2 months? ☑No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	⊒Ectopic ⊒ Other (pregnancy specify) _	y 		-	23d. Date of deli Month	very Day Year
7.	w requires that the de been signed by the should be detached	by Ph	Part II. Other signi	ficant conditions	contributing to death	but not res	ulting in the u	nderlying	cause giv	en in Part I.				the cause of death?
ora	require sen sig nould b	ted									1[Yes	2⊠No 3□Pro	obably 4 Unknown
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DIVISION	af or Attendir s after death. al Director: Af ed in by the fu	Certification;	4 Homicide	determined	289. Place of if	njury - At ho etc. <i>(Specif</i>	ome, farm, st	reet, facto	ory, office			(Street Town, Sta	and Number or Ru ate)	ral Houte Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the bes miner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurre vestigation	d at the ti	me, date and place opinion, death occ	e, and due to the urred at the tim	ne cause e, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and	d title of certifier	. 0	MD		2		se number		29d. [Date signed (Month	n, Day, Year)
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Ì	t		RENU	E. THON		670	N.C	HARL		T, TOWS	ON, M	D 2	21204	
•	Sta Regist		31. Date filed (Mon	JUL 11	2005 32. egis	trar's Signa	ture A	met	,					

Patient KnownAs Michael P. McLaethy

Box 68760,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician July MTCHAEL. PATRICK 2005 McCARTHY 8:45 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Sinai Hospital of Baltimore Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Yrs. Director 060-30-0234 67 New York 6. 1938 Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner nust be notified at 1 X Yes 2 □ No Director Marvland N/A Caltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 308 Edgevale Road 21210 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Education 5+ years History Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph McCarthy Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tree once. Carol McCarthy (wife) 308 Edgevale Road Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7-7-05 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardizl Physician e disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 2 No 1 Yes after death.

Director: After this certific

in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year))0032319 leted cause of death (Item 23a) (Type, Print) 3449 Wilkens Au- Soite 300, Beltimone, MD 21229 JR MD 32. Redistrar's Signature State

Registrar

MARTINEZ, JOSE

physician:

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item#26, perMI, C645, 711/05 TT State of Maryland / Department of Health and Mental Hygiene

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	Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. lest birthd	ay) If Under 1 Year		8. Date of Bir (Month, Da			ace (State or Foreign
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φ̂.	of Heeli Item 2	- 1	20a. Method of Disposition			20b. Place of Di	sposition (Name of	1	Date	20c. Location -		n. State
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	\$1		23a. Part1. Enter the disease, shock, or heart shure.	or complications th	at caused	the death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month)

€ gistrar's Signature

2005

State of Maryland / Department of Health and Mental Hygiene ANSOID ITEM #10e&19b PER FH C845 7/Sertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) KOCK Examiner ATON SVILLE If Under 24 Hrs. 8. Date of Birth (Month, Day, R CL . If Under 1 Year TMORE HOME, IDN ROCK GLEN Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs 10 M 2□ F 237-24-78 Usual Residence of Decedent Director 08 03 filed within 72 hours after death with the Marylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ehow r then "neturel", or items 23e or 28e-f ehov the Medical Examiner must be notified at XIXYes 2□No NA Baltimore Funeral Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Bloomingdale 1218 21216 U.S.A. Road 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: Specify. Completed by XX Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3rd Grade Factory Worker Dover Poultry th end Mental Hygiei treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health end Mental ပ Johnson Rodgers Minnie Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bloomingdale
r 1218 Broomington Road, Balto, Md 2 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health er Important: If Item 27 Is eny Injury or other treu 21216 Evelyn Rodgers-Hall-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1√2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/16/05 Baltimore Co, Md Woodlawn 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** METASTATIC PLOSTAGE CANCER Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed ettending physician end for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): cete hes been signed by the e page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed this certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 1 ☑ Natural 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Tes 2 🗆 No To the Hospital or Attendir within 24 hours effer death.

To the Funeral Director: At completely filled in by the fu death. 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one)
29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H, MD ause of death (Item 23a) (Type, Print) 31. Date filed (Mo State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No 1 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** RUTH MILLS HOWLAND ROEBBER July 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTO: GILCHRIST CENTER Baltimore County TOWSON
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours Min. 1 ☐ M 2 🂢 F Director Nov 23, 1930 Massachusetts 032-22-2587 Usual Residence of Decedent daath with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Stoneleigh Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7. and Mental Hyglane. 1s markad other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Own Residence Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert Vaughn Howland Josephine Anna Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth a (Huusband) 813 Stoneleigh Road, Baltimore, ND 21212 Dr. H. Joseph Roebber 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Dapartment of H
Importent: If itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State ' 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem Grdns 7/14/2005 Timonium, Maryland 21. Signature of Functal Service Licensee

Martin D. Dawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as car had or respiratory arrest.

21212

22a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as car had or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** evarkin Cource months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and Tha taw requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 PNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Where (Specify) 1050100 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 0 1 ☐ Yes 2 🚧 No this. Certification:

Division of Vital deeth. Director

Hospitel or Attending Physician: 24 hours e within 2

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation

6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and little of certifier

29c. License number D 58303

29d. Date signed (Month, Day, Year) July 11 2005

30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

ARON Charles ws (600 N- markes)

and manner stated

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Registrar

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31. Date filed (Month, Day, Year) 32. pegistrar's Signature JUL 1 1 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per Verb., G845.0//II/05dbb Reg. No. 1 Reg. N2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005 LOBERTS **Physician** DAVID 2,00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give stated and number) 4b. City, Town, or Location of Death Examiner Baltimore andal 15 town 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-50-391 Months Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at Himore 1 ☐ Yes 2 No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 2/208 or items 23a Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural, or any injury or other traumatic avant. The Mental of ODGE. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Father's Name (First Middle, Last Be Koberts ames Mil. State. Zip Code 19b. Mailing Address A treet and Number of 9534 MD 20b. Place of Disposition (Name of comptery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 05 Prame an Addres of Facey mature of Funeral Service Livensee RA. 40 21133 ulstown 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTOROINTESTIMAL **Physician** BLEEDING /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1/20 MBOCY 10116-14 FAILURO DENTZ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy 1 ☐ Yes X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death | Diractor: / d in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after To the Funaral Dil completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 479 05 D54288

State Registrar

DHMH 17 Rev 1/2001

JUL 1 1 2005

31. Date filed (Month, Day, Year)

Northwest Huspital Conta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

Follert Known as ROBERT ROCKLING 50. Baltimore, Maryland 21215-0036

amend item #100; e. perith, 6945; high black indelible ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ROBERT ROCKLIN 12:06 PM TULY 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY SINAI MOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 78 216-20-8707 1 M 2 □ F Yrs. OH Director JUN. 20. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10h County 10a State itam 27 is marked othar than "natural", or itama 23a or 28a-f show other traumatic evant. Its Mydical Examiner must be notified at 1 Yes 2 No RANDALLSTOWN MD BALTIMORE Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7718 PARK HEIGHTS AVENUE 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed wi h and Mental Hygien 7 Is marked othar th INVESTMENTS SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GOLDFADIM ROCHLIN EVA BENJAMIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Is n any injury or other traum once. - BALTIMORE, MD 21208 11 SLADE AVENUE, #301 GLORIA LONDON / SISTER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State SHAAREI TFILOH 07/08/2005 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Tolero 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPUXIA SECONDARY TO SEVERE PNEUMONIA day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions any, leading to in solid cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☑No 1 Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES - 000 JULY 5, 2005 Wik hil Magazwal 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIKHIL AGIARWAL of Baltimore MO Sinai Mospital 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Bour Registrar

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Physicia /Medica Examine

Funeral Director

death with the Maryland

permit. Pages 1 and 2 should be tiled within 72 hours after geath with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f ehow any injury or other traumatic event. The Madical Examinating the radiation and once.

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the daath certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	1- For Unpend Item Registrar	23a,27,28a-	f per me	G846 8-16	5-05 tas	ivientai rryg : R	eg. No.	•	
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in . al	Charles G. Radi	tko				July	Day 5	2005	9.35 P
aı er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat		4c. Coun	ity of Death	
× .	Johns Hopkins Bayy			Baltimor				n/a	
	5. Social Security Number 6. Security Number 1.2	x 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	Coun	
	218-42-6759 Usual Residence of Decedent		60 115.			10/3	L/44	Mar	yland
	10a. State 10b. County	10c	. City, Town or Lo	cation				1	0d. Inside City Limits
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une	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ri	ace - Americ lack, White,	
y F	1 Never Married 2 Married 3 ★ Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: V 1 e	o to one	1 ☐ Yes 2 🗷 No	Specify:		Spec		
Be Completed by Funeral Director	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ition		16b. Kind of		ite dustry
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မ	Fredrick J. R					L Maryar			
	19a. Informant's Name/Relationship (T)	1997		ng Address (Street a			•		
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	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	•	natory or other place					_
	21. Signature of Funeral Service Ligens			Cremato			Baltin Ome P		Mu.
	Cucana V	Costs		201 Dune					. 21222
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edicai	•	d							
/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr					23d. [Date of delive	ery
icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnancy Other (specify)			1	Month	Day Year
hys	9 ☐ Unknown	9□ Unknown							
by F	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co		he cause of death?
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70	1 ∑Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time o		4 🗀 Nursing I	Home 5 Resid			(y)
tion	1 ☐ Natural 5 ☐ Pending	(Month, Day Yea	ar) Injury	Work	Yes 2 X No				ruck head
fica	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, str			28f. Location (S	treet and Nu	mber of Buts	alRoute Number
Serti	4 Homicide	Home	pecify)			Baltimo	re, MD	44 E11	icott City
cai (vsician: To the best of my							
Medical Certification: To Be Completed by Physician/M	one)	iner: On the basis of exa and manner stated.	mination and/or in						
2	29b. Signature and little of certifier			29c. License			29d. Date sig	ned (Month,	Day, Year)
((certain)							July_	8	2005
	30. Name and address of person who c	ompleted earlie of death	(Item 23a) (Type,		enn Stre	ot Roll	imoses	M	1 01001
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State Registrar 31. Date filed (Month, Day, Year) JUL 1 1 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Spay **Physician** JEORGE SAMPSON JUU 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/AMercy Medical Center Baltimore tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, October 9, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 242-54-6928 66 Yrs. Director NC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic avent, the Medical Exemplest must be notified at 1 ☐ Yes 2 XNo Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ō Items 23a 8047 Mid Haven Road 21222 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ō 1 ☐ Yes 2 ☒ No Specify: American Indian 3 ☐ Widowed 4 ☐ Divorced "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 years Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ? Mary Jane Locklear Howard Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 8047 Mid Haven Road, Dundalk, MD. 21222 Nancy Sampson wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of P Important: If ita any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 11,2005 Baltimore City, MD. Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 r complications that caused the death. Only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death PLEUNOMA tmmediate Cause (Finat Physician ORGANIZING disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚾 Inknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 Tyes 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ٥ 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of

The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

or Attending Physician: After the hours after deat in by

Certification;

Medical

State

Registrar

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

within 24 hours a

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier JUSEPH

5 Pending investigation

6 Could not be

29c. License number

PLACE

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

BACTIMORE, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 770 301 ST

31. Date filed (Month, Day, Year)

JUL 1 1 2 2005



Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>005</u> Physician Shelley 10, 9:25 PM Harry July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3148 Yorkway Dundalk If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 3, 1928 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X**]M 2□ F Hours 213-20-7226 77 Yrs Director MD. Usual Residence of Decedent death with the Maryland 10a. State ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at Yos 2 □ No N/A Baltimore MD. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 155 Grundy Street Apt 106 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Steel Painter 8 years 7 Is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Pages 1 and 2 should be Ida Davis Edward Shelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If Item 27 Is or other tra 3148 Yorkway, Dundalk, MD. 21222 daughter Tracey Hahner 20b. Place of Disposition (Name of cemetery, crematory or other place) July 14, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. Mt Carmel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Baltimore, MD. ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P. A
7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service Licenses 21222 e or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sustrice uncer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Exam Due to (or as a consequence of): physician au the burial-t Box 68760, Physician/Medical attending p IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 5 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No page 2 s rmed2 2 No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 □Other (Specify) ihis After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person S105505 Circle Hopkins Bayview 31. Date filed (Month, Day,) Year) Registrar's Signature State Registrar

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	Funeral Director		5. Social Security Number 6. Se 2/9-/0-377/	7. Age (In y/s. last		f Under 1 Year Months Days	Hours Min.	(Month, Day, Y	(ear) 9. E	Birthplace (State or Foreign Country)
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	/		30 Name and address of person who			rint) B-	lais K	d BAH		10 3:= 5:
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Regi	State istra	-	31. Date filed (Month, Day, Year) JUL 1 1 2005 Registrar's Signature	,		t	,

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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any figury or other traumatic event. The Medical Evain art must be footliked at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ☑ No	? (Specify Yes or N Puerto Rican, etc.)		4. Race - Ameri Black, White,			
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Δ.	es tha gned be de	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Fart I.								he cause of de	
Vital Records,	e law requir has been si je 2 should	Completed						24a. Wa.	s an opsy ormed?	24b. Were auto prior to co death?	ppsy findings a mpletion of ca	available luse of
la F	iclan: The certificate rector, pag	e Cor	25. Was case referred to medical				OC Place of	1 ☐ Yes	2□No	1 Yes	2 🗆 No	
f Vii	Attending Physician: r death. actor: After this certific. by the funeral director,	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Ot	hon	Death (Check only ing Home Aes		Other (Special	(y)	
n of	ding Pt h. After th funeral		27, Manner of Leath	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Desc ibe	how injury	occurred		
Division	or Attendl after death. Diractor: A in by the fu	ficat	Accident investigation 3 Suicide 6 Could not be determined	e de Bless et Firm. At h	ome, farm, str]Yes 2⊡No		(Street and	Number or Run	al Route Numb	00 <i>r</i> ,
Ö	tal or A s after al Dirac ed in by	Certification:	4 Homicide Getermined	building, etc. (Speci	fy)			City or To	own, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Place Certifying Certifying Place Certifying Place Certifying Place Certif	nysician: To the best of my knomer: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and p opinion, death	place, and due to the occurred at the time	cause(s) a , date and p	and manner as s place, and due t	tated. o the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	1/100	2011	29c. Licen	se number	7 6-	29d. Date	signed (Month,	Day, Year)	
,	1		30. Name and address of person who	completed cause of death (Its	n 28a) (Type,	Print)		<u> </u>	11	11/2	J	
	18		171-11	les St Towsen	M	21204	tau	1 Valle	ni	7.		
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 1 20	32 Registrar's Sign								
DH	MH 17 Rev 1/2	-	20	05 Here L	- John							

			For State Registrar	State of Maryland	l / Depa <i>Cer</i>	artment of F tificate of I	lealth and M <i>Death</i>	lental Hygi Re	ene 005	22599
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Alberta Amelia S					July 8,	2005	7:30 A M
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
	Funeral		115 Warwick Driv		st birthday)	Lutherv If Under 1 Year	1110 If Under 24 Hrs.	8. Date of Birth	Baltim 9. Bi	
	Director		213-14-8747	□M 2XF 86	Yrs.	Months Days	Hours Min.	(Month, Day,		rthplace (State or Foreign ountry)
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	lor	Maryland Baltimo		utherv					1 ☐ Yes 2 X No
	ith the Marylar or 28a-f show	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a c 23a c ust be	alD	115 Warwick Drive			21093		U	SA	
	er des Items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
39	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:		1 ☐ Yes 2 况 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland natural; or tems 23a or 28a-1 show deat Enstainet must be indified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occup	ation during most of worki	ing 1	6b. Kind of Business	s/Industry
121	vithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	d) -	9		
р П	filed v Hygie ther t		17. Father's Name (First, Middle, Last)			lomemaker	18. Mother's Name	(First. Middle, M	Ow⊓ laiden Sumame)	Home
Maryland	lid be lental ked o	To Be	Frank Mickus				Alberti			
ary	shou and M s mar	_	19a. Informant's Name/Relationship (Type, Print)		-			City or Town, State,	,
Σ,	and 2 ealth m 27 h		Loretta Vandenbe		The second second				e, Maryla	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it a Modical Ensirther must be intillized at once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Degnation 5 □ Other (Specify	Removal from State	metery, crer	sition (Name of matory or other place F Faith C	ce)	3/2005	Oc. Location - City o Parkvill	
Balti	permit. Departn Imports any inju		21. Sign ure of Funeral Sérvice Licer	S. Coster		2. Name and Addre	ss of Facility Ru Road, To			Home, Inc.
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	RENM	FAIL	une				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
		ē	Securationly list duncitions	b. Due to (or as a consequ	ence of):	Rema				
	d d ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	e exec ian ar urial-tr		resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	ficate be executed g physician and as the burial-transit	edical		d				· · · · · · · · · · · · · · · · · · ·		
Вох 6	The Control		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of de	elivery
	0 0 0	Physician/M	in the past 12 months? 1 🗆 Yes 2 🔊 No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)	/		Month	Day Year
P.O.	that the do	Phys	9 Unknown	9□ Unknown						
ds,	es ign be	i by	Part II. Other significant conditions of Concouracy Arterior							to the cause of death?
COL	w requir	letec	· · · · · · · · · · · · · · · · · · ·	eacomy aparmy	_		7	24a. Was an		utopsy findings available
of Vital Records,	The law ate has b page 2 sl	Completed by	,	E, DINSETES	, , ,			autopsy perform	prior to led? death?	completion of cause of
ital		Be C	25. Was case referred to medical examiner?	E, WINSETES	, 1.71	"ZCIENS	26. Place of Death			5 2 140
× ×	Physician: this certific ral director,	To	1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3□ DOA Oth	ner: 4 ☐ Nursing Ho	me 5 Resider	nce 6 □Other (Sp	ecify)
o uc	ding P. h. After t funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Wor	yat rk? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	r Attending er death. rector: After by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not b		ne, farm, str			28f. Location (Str	eet and Number or F	Rural Route Number.
Ö	spital or vours after seral Dire	Certi	4 Homicide	building, etc. (Specify,				City or Town,	State)	
	Hos Hur ely	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exar	ysicien: To the best of my knowniner: On the basis of examination and manner stated.	viedge, deat ion and/or in	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) and manner a te and place, and du	is stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7/		29c. Licens			d. Date signed (Mor	
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i	5			completed cause of death (Item	23а) (Туре,	Print)	200 1	IIIam A	100.11.	71002
Ĭ	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure		in / lone	,	- 11 - Y LATHE	61093
	Registr		JUL 1 1 20	completed cause of death (Item /// /ZZZ/ 32. Registrar's Signat	2 Ago	rotes				

			For State Registrar	te of Maryland / [rtment of l		and Mer		-	005	22600
	Physicia		Decedent's Name (First, Middle, Last)						Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic Examin	al	Edwin E. Segal1 4a. Facility Name (If not institution, give street a	and number)		4b. City, Town,	or Location o		uly 4		5 ounty of Death	2055 M
	CXdIIIII	er	Holy Cross Hospital			Silver					ntgome	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		If Under 1 Year Months Days	If Under	24 Hrs. 8.	Date of Birtl (Month, Day	Year)	9. Birth	place (State or Foreign intry)
	Director		508-12-2644 Usual Residence of Decedent	81	Yrs.			Ju	1y 17	, 192	3 Neb	raska
	yland yland		10a. State 10b. County	10c. City, Tow	n or Loc	ation						10d. Inside City Limits
	e Mar	ctor	Maryland Montgomery	Kensin	gto	n						1 ☐ Yes 2 🎇 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citizer	n of What Co	untry?
	eath v	erai	4301 Knowles Avenue	as Decedent Ever in U.S.	13 V	20895		gin? (Specify			d Stat	
9	after d		An	med Forces? Yes 2 No World Yes, Give		/as Decedent of Yes, specify Cut			an, etc.)	1	Black, White	
003	ural', c	d by	3 22 Wildowed 4 Divorced Ye	ar or Dates: War Ⅱ		☐ Yes 21 No				St	рес <i>ity:</i> Wh	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f ehow thit, the Mcdred Examiner must be mailfied at	Completed by	15. Decedent's Education (Specify only highest grade comp	oleted) 16a.	(Give I	ent's Usual Occu kind of work done O NOT use retire	during most	t of working		16b. Kind	of Business/l	ndustry
212	d withi	dwo	Elementary/Secondary (0-12) Co	llege (1-4or 5+) 5+ Di	iplo		,			Fore	ign Se	rvice
ng	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (Fi	irst, Middle,			
yla	ould b	2	Harry Segall					th Whi				
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, Pr	1		g Address (Stree				-		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-4 show any injury or other traumatic event, the Modest Examiner must be notified at ance.		Becky Segal1/Daughte 20a. Method of Disposition	20b. Place o	f Dispos	Bradle		evard. July 8,			tion - City or	
E	Page: nent o int: If		1 🖾 Burial 2 □ Cremation 3 □ Remove '4 □ Donation 5 □ Other (Specify)	ai from State	-	atory`or other place k Cemet		iury 8, 2005		Wash:	ington	D . C .
Baltimore,	permit. Departn Imports any inju		21. Signatur of Foreral Service Licencee	,	22 B.o.	Name and Addr			t_A.	Pumph	rey Fu	neral Home/
	2011		1 Carolle Per	M00803							Wisco	neral Home/ nsin Avenue
	Pnysician /Medical Examiner			Asystole Due to (or as a consequence		a tile mode or dy	ing, such as	cardiac of 16	зрнатогу аг	rest,		Approximate Interval Between Onset and Death
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.O. Box 6	death certif e attending ed for use as	Physician/Medical	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown		Ectopic pregnan Other (specify)	су			230	d. Date of deli Month	very Day Year
rds, P	se us	þ	Part II. Other significant conditions contribut	ng to death but not resulting i	n the ur	derlying cause g	iven in Part I					the cause of death?
Vital Record	The law requii ate has been s page 2 should	Completed								med?	prior to death?	topsy findings available completion of cause of
ita	ician: T certifical rector, p	Be C	25. Was case referred to medical				26. Place	of Death (C		2 No	1 🗆 Yes	2 X No
of V	di is	2	examiner? 1 Yes 2 No Hospita	1 ☐ Inpatient 2 ☐ ER/O	-						Other (Spec	ify)
ion o	ding h. After fune	ertification;	1 Natural 5 Pending 2 Accident investigation		Time of Injury		ury at ork?] Yes 2 []		. Describe h	now injury o	occurred	
Division	tal or Attens s after deat al Director: ed in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined 28	 Place of Injury - At home, fa building, etc. (Specify) 	arm, stre	eet, factory, office		28f.	Location (S City or Tox		Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examiner: C	To the best of my knowledge on the basis of examination are and manner stated.	e, death nd/or inv	occurred at the restigation, in my	time, date an opinion, dea	nd place, and ath occurred a	due to the at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	To the Vithin 2 To the Complet	Σ	29b. Signature and title of certifier			29c. Licer	nse number			29d. Date :	signed (Monti	n, Day, Year)
	17		() 014 CU	mee		D394	52			July	7, 20	05
5	1'		30. Name and address of person who complet Lila T. McConnell, M				M10 #.	1,600	Ch	Cl.	- MD	20015
Ĭ	Sta	ite	31. Date filed (Month, Pay, Year)	D. 5530 Wis	COIL	TII Avei	iue, ∦.	1400,	cnevy	unas	e, MD	20815
	Regist		JUL 1 1 2002	STA PS 19	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Reg. No. 200 Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death Month **Physician** oma 2005 07 - 10 AM 06 /Medical institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8. Date of Birth Month, Day, Year) 2-26-C 6. Sex Age (7) last birthday 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2**X** F Director -1002 Usual Residence of Decedent Maryland 10a. State 10b. County 10d. Inside City Limits City, Town or Location 28e-f shov traumatic event, the Mudical Examiner must be notified at timore 1 Yes 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or Items 23a or 6 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned permit. Pages 1 and 2 should be filled within 72 hours af Department of Health and Mental Hygiene Important: If Item 27 ia marked other than "natural; or any injury or other traumatic event. Its Muster France. Baltimore, Maryland 21215-0036 1 ☐ Yes MNo Specify: Completed by **2** Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use seried) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Mother's Name (First, Middle, Maiden Suma, Be (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address 10.MD21239 Method of Disposition

□Burial 2 □ Cremation 20b. Place of Dispos 3 Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 00 1 to MD 23a. Part1. Enter the dease, or complications that caused the death. Do not enter shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): tross Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner or Attending Physician: The taw requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an GOU has autopsy certificate 1 Yes 2 N in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 1 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Beath 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural after death. 2 🗌 No 1 Yes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 6-05 60539 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

Registrar

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Registrar's Signaruse

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amend item/17,18, periff, 6845. //II/05 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 8, Catherine Stones Taylor 2005 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care of Cherrywood Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Jan. 23, 1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M XXF Days Hours Virginia 67 Director 227-50-1350 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes ANO Director MD Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or 5 Plesant Ridge Dr. Apt.103 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XXMarned Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: þ Specify: 3 Widowed 4 Divorced Black natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith end Mental Hygiene. 27 le marked other then "I r traumatic event, the Med Elementary/Secondary (0-12) 12 College (1-4or 5+) Disability Claims Rep. Social Security 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)
Orabelle Watkins Be Pages 1 and 2 should be in nent of Health end Mental ္ရ Latoye Stones Ora (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills Item 27 other tr 5 Plesant Ridge Dr. Apt.103 Taylor /Husband Stafford G. 20c. Location - Cry of Fwn, state 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If It eny Injury or o Murial 2 □ Cremation 3 □ Removal from Maryland Vet. Cem. 7/13/05 Owings Mills, 4 ☐ Donation 8 ☐ Other (Specify) un rai Ser 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Myloma **Physician** nhum disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Cher (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 No 1 🗌 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 Yes 2 No Certification: To 3 DOA 5 Residence 6 Other (Specify) funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel 29a. Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely 2 Madeal Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the 29d. Date signed (Month, Day, Year) 29b. Signature and title 127569 118/05 1838 Greene True del 30. Name and address of 31. Date filed (Month, Day, 32. Ragistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 3

Registrar's Signature

			1 - State of M	aryland / Depa <i>Cei</i>	artment of H			ene . No. 2005	22601
			Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physici /Medic		Jane M. Tobin				July 8,	2005 Year	11:15P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		_	Location of Death		4c. County of Death	
			Wilson Health Care Centers S. Social Security Number 6. Sex 7. Ac		Gaithers	burg	O Data of Right	Montgome	7
	Funeral Director		027-18-8559	e (In yrs. last birthday) 86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) Dec. 7,	ear) Coi	place (State or Foreign untry) Sachusetts
	D		Usual Residence of Decedent				Dec. 7,	1)10 Ilas	sachasetts
	aryler show	-	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	28a-f	Director	Maryland Montgomery 10e, Street and Number	Gaithersb		- Civi			
	with	ā			10f. Zip Code			. Citizen of What Cor	•
	me 23	Funeral	403 Russell Avenue, #304 11. Marital Status 12. Was Decedent	Ever in U.S. 13. \	20877 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp		nited Sta	
စ္	or ite	Fur	Armed Forces? 1 □ Never Married 2 X Married 1 □ Yes 2 X If Yes, Give	No	f Yes, specify Cuba 1 □ Yes 2 🕱 No		Rican, etc.)	Black, White	, etc.
993	72 hours after deeth with the Marylend Insturel', or iteme 23e or 28e-f show Jissi Exaculted aust be nutified at	d by	3 Widowed 4 Divorced Year or Dates:					Specify: Wh	ite
15	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	sing 16	b. Kind of Business/I	ndustry
12	withi	omp	Elementary/Secondary (0-12) College (1-4or 5+	0+)	eacher	/		ublic/Pri	vate School
ğ	e filec of Hyg of he vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma		Vace Benedi
lar	Menta Menta arked	ToE	Michael J. Herlihy			C. Lou	ise Cunne	У	
Jar	2 sho and ie ma		19a. Informant's Name/Relationship (Type, Print)	1				ity or Town, State, Z	
e) 'e	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mental Hyglene. Importents if item 27 is marked other then "naturel", or iteme 23e or 28e-f show any injury or other treumatic event, the Marical Exacting or ust be nutitied at once.		Charles A. Tobin/Husband 20a. Method of Disposition					hersburg,	
Baltimore, Maryland 21215-0036	nt of h		1 ☐ Burial 2 ACremation 3 ☐ Removal from State	20b. Place of Dispo	natory or other place	July	13,	c. Location - City or 1	
틆	artme orten injury		' 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature 3: □ neral Service Lice is e	Cremator	Lum, Inc.	2005	ert A. Pi	Bethesda, Imphrev Fu	Maryland neral Home/
Ba	Depariment Department Impo		Maril Eleny	M00803 Be	thesda-Ch	nevy Chas	e, Inc. 7 20814-35	557 Wiscon	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death. Do not ent					Approximate Interval Between
	Physician		. ,		hear	txaile	ure		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	estine a consequence of): utensine	/.	0	/ /		
Н		-	Sequentially list conditions, if any leading to immediate	a consequence of):	carde	ovace	ulded	Heale	
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	2 0011304201100 01).					
oʻ	exect an and rial-tra	Exa	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
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9	death certifica attending pt d for use as t	Med	IF FEMALE:	-4					
Вох	attenc for us	Physician/Med	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
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α.	The law requires that the death certific lte has been signed by the attending p page 2 should be detached for use as		Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	on in Part I.	23e. Did tobac	co use contribute to	the cause of death?
of Vital Records,	w require been sig should b	Completed by	curone allest files	uccen,	Hypere	ender	1 ☐ Yes	2 INo 3 □ Pro	bably 4 Unknown
ecc	e law r has be je 2 sh	pie	Dichetes! Recent.	septice	mus,"	nemua	24a. Was an autopsy	prior to o	opsy findings available ompletion of cause of
<u>~</u>		Con	of chedrical serve,	talipny	alged		performe 1 ☐ Yes 2 ☑	death?	2 □ No
Ziti	Phyeiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othe	10	h (Check only one)		
of	Phye	. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		IL 3LI DOA	4 Nursing Ho	ome 5 Residence 28d. Describe how	e 6 Other (Specinium occurred	fy)
Division	ttending death. stor: Afte	Certification:	1 Matural 5 Pending (Month, Da 2 Accident investigation	y Year) Injury	Work	í? Yes 2 □No			
Vis	r Atte er dea recto by th	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui	al Route Number,
	Hospitei or Attending I 24 hours after death. Funerei Director: After tely filled in by the funer								
	Hospite 24 hours Funerei etely fillec	edical	29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of and manner et and manner	f examination and/or inv	n occurred at the time vestigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitei or Attending Ph within 24 hours after death. To the Funerei Director: After th completely filled in by the funeral	Med	one) and manner st 29b. Signature and title of certifier	ALBU.	29c. License	number	29d.	Date signed (Month	. Day, Year)
)	- s + s		VI Robert Dysikh	alko	000	+115	4	ulu 9.0	2005
i) 4		30. Name and address of person who completed cause of c	leath (Nem 23a) (Type,	Print) 201	RUSS	CLAUS	NUE.	1.4.
1			14, ROBERT BIRSCHBACK	4, RLD	GA	THERS	BURG,	VIB 200	77
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 1 1 2005	ar's Signature	()		,		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner H Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Arendel medicul Arundy Anse leite Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2/2(F 577-26-7659 Usual Residence of Decedent Director 10vember 11, 1918 MARYLAND 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examinar must be notified at Sunderland 1. Yes 2 □ No Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or filed within 72 hours after death with P.O Box 20689 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2d No RICAN AMERICAN Completed by 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) othar than College (1-4or 5+) Domestic RIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be filt partment of Health and Mental Hyportant: If item 27 is markad othey injury or other traumatic evanty injury or other traumatic evanty /homas DANIEL 19a, Informant's Name/Relationship (Type, Print) (Drugs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 414 -CEORGIA LEE Shia Baltimore, 20b. Place of Disposition (Name of gemetery, crematory or other place) Date 20a. Method of Disposition - City or Town, State permit. Page Department o Important: If any injury or once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State Church 4 □ Donation 5 □ Other (Specify) tock 22. Name and Address of Facility
PANCEY M. CEACE ARE FUNE
3405 W. FRANKLIN SHEET-BA 21. Sharp re of Funeral Service Licenses 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) ANO Approximate Interval Between Onset and Death week **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) burial-transit or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ate has been signed by the atterpage 2 should be detached for a in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 🔎 No 20 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Monpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28b. Time of After t 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (ABRAHAM) 00056658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMC, 2001 Parkeya Litus han 31. Date filed (Month, Day, Year) 32. Signature State 2005 Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Marylan	d / Depa		alth and M	lental Hyg	•	
Physi /Med	dical	Decedent's Name (First, Middle, Last) Stewart A. V			Ab City Town or I	agation of Poeth	2. Date of Deat Month July 9,	Day Year	3. Time of Death 6:30A M
Exam	iner	4a. Facility Name (If not institution, give s 10412 Rutlan	d Place		4b. City, Town, or L Adelphi			Prince	George's
Funera Directo		5. Social Security Number 6. Sex 215-48-6215 Usual Residence of Decedent	7. Age (In yrs. 44	last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 17	, 1960 Wa	irthplace (State or Foreign Country) shington D.C.
Marylan -f show fled at	tor	10a. State 10b. County Maryland Prince G		y, Town or Loc lelphi	ation				10d. Inside City Limits 1 ☐ Yes 2 No
with the 3a or 28e	i Director	10e. Street and Number 10412 Rutlan	d Place		10f. Zip Code 20783		1	Og. Citizen of What C United St	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland operatment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23a or 28e-1 show any Injury or other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 🛣 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: WI	nite, etc.
1215-0 within 72 ho ne. hen "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give k	ent's Usual Occupati ind of work done du O NOT use retired) .room Supe	ring most of worki	ing	16b. Kind of Busines	
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Mary and 2 should be alth and M 27 is main in treumating		19a. Informant's Name/Relationship (Ty, Marla Allentuck,		19b. Mailing 6217	Address (Street and Lilac Bus	sh Lane,	Al Route Number Clarksv	; City or Town, State, ille, MD	Zip Code) 21029
imore, Pages 1 a nent of Her ant: If Item ury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)			ition (Name of atory or other place) d Memoria	July ^t lGarden	2005	20c. Location - City o	
Balt permit. Departr Importe any Inji	Suce.	21. Signature of Funeral Service Licens	lerold.	72 72	Name and Address TChinsky 4 Carroil shington	Hebrew I	Funeral 2	Home	
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/Medica Examine	r	Sequentially list conditions.	Due to (or as a consect. Due to (or as a consect.						
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I Records, P.O. Box 68' The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
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Division of Vital To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at		ow injury occurred	
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To 1 To 1	×	29b. Signature and title of certifier	no.		29c. License			July 11, 2	
		30. Name and address of person who co	mith ma	401 N		edway 1	3 altimore	July 11, 2 Marylan	el 21231
	State strar	31. Date filed (Month, Day, Year)	32. Repart's Sign	ature	Gulis			*	

ORIGINAL

DHMH 17 Rev 1/2001

PT KNOWN AS 151AH WALFER
Baltimore, Maryland 21215-0036

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Box 68760,
P.O.
Records,
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of
Division

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Funeral Director		213-52-2249	180 M 2□F	55	Yrs.	Months Days	Hours Min.	(Month, D	31 Year)	O 9. Birting	place (State or Foreign ntry) WV		
pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Tour or Lo	antian							
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irs afte	by F	Wever Married 2 Married 3 Widowed 4 Divorced	XXYes 2 ☐ I If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🔀 No	Specity:		S	pecify: R1	lack		
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s mar s mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Rur	ral Route Num.	ber, City or T	own, State, Zip	Code)		
and 2 ealth in 27 i		Ruth Walker-M	other				kson Rd		timor	e, Md	21244		
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it. Pa urtmen urtent: njury	- 3	* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	-	Gar		n Fores Name and Addre		7/13/0	5 Owi	ings M	ills, Md		
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requir een si								1	Yes 2 1	No 3□Prot	pably 4 Denknown		
The law cate has b page 2 sl	Completed							24a. Wa aut	s an popsy formed?	24b. Were auto prior to co death?	ppsy findings available impletion of cause of		
	e Co	OS Man and referred to an dist						1 🗆 Yes	2010	1 Yes	2 No		
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or At	Certification:	4 Homicide determine	286. Place of in	jury - At hom- tc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or To	(Street and I own, State)	Vumber or Rura	al Route Number,		
spitel ours and perai		29a. Certifier 1 Certifying	Physicien: To the best	of my knowle	edge, death	n occurred at the tir	me date and place.	and due to the	e cause(s) ar	nd manner as s	tated		
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	of examination	n and/or in	vestigation, in my o	pinion, death occur	red at the time	, date and pl	lace, and due to	o the cause(s)		
To the within To the comp	M	29b. Signature and title of certifier	/			29c. Licens				signed (Month,			
		* securefly	plu			MD PS	70693		Ju	1 05, 2	2005		
6+1		30. Name and address of person of AUDEN G. PE	OPUES, MD	death (Item 2			F BACTIN	ropes					
Sta Registr		31. Date filed (Month, Day, Year) JUL 1 1 2005	32. Registr	rar's Signatur		9							

			1 - For State Registrar	State of	f Marylan		artment of F rtificate of				ene g. No.		
ı	Physici /Medic		1. Decedent's Name (First, Middle,		an A. W	arren				Date of Death Worth July 4	20	9.5	32 ima of Deam 8
	Examir		4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Town, o	r Location	of Death		4c. County	of Death	1
			Manor Care-Chev	y Chase			Chev	y Cha	se		Mont	gome	ry
П	Funeral Director		5. Social Security Number 225–05–2506	5. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 95	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. Fe	Date of Birth Month, Day, b. 19,	Year) 1910	Cour	place (State or Foreign ntry) York
	p .		Usual Residence of Decedent										
	show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					1	0d. Inside City Limits
	88-f	octo	Maryland Montg	omery			Bethesda	3					1 ☐ Yes 21 No
	vith th	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	hat Cour	ntry?
	s 23s	ral	4504 Harling La			0 145		20814			Jnited		
3	72 hours aller death with the Maryland naturel; or Items 23a or 28a-f show Jical Exantreer ust be neitliked at	by Funeral (11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 X No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Ori an, Mexicai Specify:		Yes or No- n, etc.)		k, White,	can Indian, etc. hite
3	"naturel",		15. Decedent's		103.	16a Dece	dent's Usual Occup	ation			6b. Kind of Bu		
2		Completed	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retired	durina mos	st of working	'	Orthop		dustry
21215-003b	y within piene. r then *	mo	Elementary/Secondary (0-12)	College (1	-40r 5+)	Phys	ical The	apist	t		Doctor		
	be filed within tal Hygiene. od other then event, II.o.W.	a l	17. Father's Name (First, Middle, La	ist)				18. Moth	er's Name (Fire	st, Middle, M			
Maryland	should be ind Mental is marked o	To B	George H. Stel	zer				Ros	se Mari	e Muri	су		
a	s ma	, n	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numb	er or Rural Rot	ute Number,	City or Town,	State, Zip	Code)
Ξ	and 2		Walter D. Warren	, Jr./Hus	band	4504	Harling	Lane,	Bethe	sda, M	ary1an	1 208	314
2	of He item		20a. Method of Disposition		1 6	cemetery crei	sition (Name of matory or other plac	ce)	Date Tar 1 0	2	0c. Location -	City or To	own, State
Ĭ	Page nent: If int: If		1 ☐ Burial 2 🖾 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		MOI MOI	itgomei	um, Inc.		July 8 2005	, E	Bethesd	a, Ma	aryland
Dallillore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other traumatic and ones.		21. Signature of Funeral Service Li	censee	м00	Rec	Name and Addre obert A. 57 Wiscon	ss of Facili Pumph	rey Fur	neral	Home/Be	thes hase	da-Chevy
ĺ,	Si e		23a. Part1. Enter the disease, or or shock, or heart failure. List or	omplications that cally one cause on e	aused the deat ach line.	h. Do not ent	er the mode of dyir	ig, such as	cardiac or res	piratory arre	st,	014	Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)	a Stro									5 days
	Examiner				oras a conseq	-	. 01	1.	D	•			
,	cate be axecuted physician and the burial-transit	l Examiner	Sequentially list conditions, it by leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uenos of):	t Clostri	.dlum	DIFFIC	ile Di	arrhea		o months
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j	at the death certifit by the attending p tached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Yes		•
٦ (۵۵) ٦	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Part I.							e. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 {		
100	The law ate has b page 2 sl	Completed								24a. Was an autopsy perform	ed?	Vere auto rior to cor eath? Yes	psy findings available mpletion of cause of 2 No
N N	icien: certific rector,	Be	25. Was case referred to medical examiner?				1,171	26. Place	of Death (Che	eck only one)		
5	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Mont		ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	v at			nce 6 Other		y)
=	spitel or Attending ours after death. erel Director: After filled in by the fune	Certification	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At he	ome, farm, str y)	reet, factory, office	.00 20	28f. L	ocation (Stre City or Town,	eet and Numbe State)	er or Rura	I Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (29a. Certifier 1X Certifying (Check only one) 2 ☐ Medical E	Prysicien: To the aminer: On the ba and mann	isis of examina	wledge, death	h occurred at the tir vestigation, in my o	ne, date an pinion, dea	nd place, and d ath occurred at	lue to the cau the time, dat	use(s) and ma te and place, a	nner as st	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and fille of certifier	//	// .	Ø	29c. Licens	enumber		29	d. Date signed	(Month,	Day, Year)
	4) (/m	01/11	MIL	911		D0417	9		July 5,	200	5
	12		James J. Foster			n 23a) (Type, sconsir	Print) 1 Ave.,#9	25, C	hevy Ch	nase, l	Marylar	ıd 20	815
	Sta Registr		31. Date filed (Month, Day, Year)	2005	egistrar's Signa	ature	adi						

EN WU	1.	- State Unpend Item 2	State of 3a,pt.	Maryland II,27 pe	l/Depa e rme ∂	irtment \$# ēa₹e	of He	eaith a M a <i>t</i> ha	na me s	ntai Hyg	eg. No.	2005	5 2	2609
* *	1.	Decedent's Name (First, Middle, Last,								. Date of Dear		O C Year		e of Death
Physician /Medical		Ai-Lien Wu								JUNE		2005 ^{Year}	095	50 A ^M
Examiner	4a	. Fecifity Name (If not institution, give				4b. City, T		Location of				ounty of Deat		
· .	L	5717 Mayfair Mano			and the limbs of a coll	If Under 1		kville		. Date of Birth		ontgome		ite or Foreign
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Director		suef Residence of Decedent					1		`	JCC. 1	, -,			
A III	-	Da. State 10b. County		10c. City	, Town or Lo	cation								e City Limits
naturel', or liens 23s or 28s-f show digal Examination profitted at eted by Funeral Director	1	Maryland Montgome	ery	Ro	ckvill	.e							10	Yes 2XNo
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ner ner	1	1. Maritaf Status		dent Ever in U.S	S. 13.	Was Decede	ent of Hi	spanic Orig n, Mexican	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	1	 Race - Ame Black, White 		n,
el, or items 23a or 28a-1 el Examinar must be notified by Funeral Director		1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes If Yes, Give Year or Da	ө	1	1 ☐ Yes 2		Specify:				Specify: As	sian	
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7 le marked other then "naturel traumatic event, tra Medical E. To Be Completed b		Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	e retired)			Nat:	ional]		utes
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1 P		Ren Kuei Wu				-			n Sha		0.4	T C4-4-	7:- Codel	
- E		19a. Informant's Name/Relationship (7										Town, State,		
m 27 sertr		Chung-Yeh Wu/Bro	ther	John B	203 A			venue	, Wal			rnia (le
1 to 1 to 1	2	0a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from	C	emetery, cre	matory or ot	her plac	(e)	July 2005			,		
ury		4 □ Donation 5 □ Other (Specify)		mator	lúm, I	nc.		2005	A	Betl	hesda,	Mary 1	Land
Important: If item 27 is marke eny injury or other traumatic gncs.	1	21. Signa on a Pineral Service Scen	500 	. моо	803 B	2. Name and ethesd ethesd	la-Cl la, N	hevy (Maryl:	Chase and	20814-	755 3501	nesda, phrey l 7 Wisco	onsin	Avenue
tor use as the buriat-transit and polytons as the buriat-transit and polytons are properties.		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (osclero (or as a consequ (or as a consequ (or as a consequ	uence of): uanca of):	ardiov	ascu	ılar I)isea:	se				
Physician/Med	The second secon	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown	1 ☐ Live t	tcome of pregna birth 2 Peta nant at time of d own	I death 3	□Ectopic pro		,			2	23d. Date of de Month	Day	Year
2	5	Part II. Other significant conditions c Gastric Cancer	ontributing to d	leath but not res	ulting in the	underlying c	ause giv	en in Part I			obacco u Yes 2[se contribute ∃No 3⊟F		e of death? 4
page 2 should	onlibies									24a. Was auto perio 1X Yes		24b. Were a prior to death? 1 X Ye	completion	lings available n of cause of
is certifical director, p	U	25. Was case referred to medical examiner?								(Check only o				
	2	ty⊡ Yes 2 □ No 27. Manner of Death 1. Manural 5 □ Pending	28a. Date (Mon	Inpatient 2 Control of Injury oth, Day Year)	ER/Outpation 28b. Time Injury		28c. fnjui Wo		2	ne 5 Resi		S Other (Sp y occurred	ecify) SC6	ene
in by the	erillicar	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	e of Injury - At h ling, etc. (Specia	ome, farm, s fy)					28f. Location (City or To	Street an wn, State	d Number or i	Rural Route	Number,
To the Funerel Director: A completely filled in by the fi		29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	niner: On the t	e best of my kno basis of examina oner stated.	owledge, dea ation and/or	ath occurred investigation	at the ti	me, date ar opinion, dea	nd place, a ath occurre	and due to the ad at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the ca	use(s)
o the	3	29b. Signature and title of certifier	Λ	0 -		290		se number				te signed (Mo		ear)
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era	1	30. Name and address of person who	AH	AU		e, Print) 11	.1 Pe	enn S	treet	Balt	imore	e, Mary	land	21201
State Registrar		31. Date file (Morth, Pay Xear)	32.	Registrar's Sign	aude de									

0456	1		For A 1 T.	State of Ma	ryland	4Depa	rtment	of H	ealth a	and M	lental Hy	giene		
		4	State Amend Item	I per ME,	, 845,0	Cel	tificate	of L	Death				105	22610
30	Physici	an	1. Decedent's Name (First, Middle, La		L						2. Date of Dea	Day	Year	3. Time of Death
W. 121/20	/Medic	al	Shia Yu Hwang 4a. Fecility Name (If not institution, gir	Shia-Yu I	awang_	-	4b. City, 1	Town, or	Location of	of Death	July 7		ty of Death	0039 A M
	Examin	er	7000 Allentown Ro				Camp	Spr	ings			Prin	ce Ge	eorge's
ار	Funeral		Social Security Number 6.		e (In yrs. las		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Dec. 17	h y, Year)	9. Birth	nplace (State or Foreign intry)
€ [Director		193-64-8582 Usual Residence of Decedent	10441 201	46	Yrs.					Dec. 17	, 1958	Tai	lwan
yland	Mod		10a. State 10b. County		10c. City, 7	Town or Lo	cation	-						10d. Inside City Limits
в Маг	18 H	ctor	MD Prince	Georges	Sui	itlan	đ							1 X Yes 2 No
dith th	or 28	Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cou	untry?
eath v	23a	erai	1608 Haney Ave.	12. Was Decedent	Ever in U.S.	13.1	Was Deced		0746	igin? (Sp	acify Yas or No	Taiw		ican Indian,
of the d	r Hen	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 24			If Yes, spec				ecify Yes or No Rican, etc.)	ВІ	ack, White	, etc.
034 ours a	Eng.	þ	3 ☐ Widowed 4 A Divorced	If Yes, Give Year or Dates:			1 Yes 2	2 EF No	Specify:	:		Spec	ify: A	sian
21215-0036 od with the Maryland	iene. rthen "netural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done o	ation during mos	st of work	ing	16b. Kind of	Business/l	ndustry
Mithie	Hygiene. other then ent, tre	d Lio	Elementary/Secondary (0-12)	College (1-4or 5			very 1		,	ın		Domin	o's P	izza
ind 2	T the	BeC	17. Father's Name (First, Middle, Las	t)							e (First, Middle,	Maiden Suma	me)	
arylar should b		To E	Dao Fa-Hwang						Chu	ien-I	an			
<u>a</u>	and s m		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbi	erorRun	al Route Numbe	ar, City or Tow	n, State, Z	Keelung,
	Heal ther		Huang Yi-Jing/ D 20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	ne of			ane Hsi	20c. Location		
S 8	5 E		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Hunt	t Cre	matory`or ot emator	ther plac Ty	θ)	7/10	/2005	Wald	orf,	MD
Baltimore,	Department important: i eny injury o		21. Signature of Funeral Service Lice		-		2. Name <i>a</i> nd			KOD	ert E.		Funer 2071	al Home
×- ×			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	mplications that caused	the death.								20/1	Approximate Interval Between
Ph	ysician		tmmediate Cause (Final disease or condition	Shoton		(:)(~)	nel	F	- 4	ors	0			Onset and Death
	Medical caminer		resulting in death)	Due to (or as	_	_								
	este Allest	<u>~</u>	Sequentially list conditions,	b. Due to (or as	a conseque	nce of):								
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60, <i>(</i>	sician and burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):								
- o	> 9	dicai		d										
oertifii	attending phy	Physician/Med	tF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome								23d. C	ate of deli	very
Box death cer	e atte	iciai	in the past 12 months?	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			⊒Ectopic pro ☐ Other (sp						Month	Day Year
P.O	ed by the detached	Phys	9 Unknown						1- 0-41		22a Dide	abassa usa sa	ntebuta to	the cause of death?
Records, P.O. Box 68 The law requires that the death certifica	been signed should be de	ted by	Part tl. Other significant conditions	contributing to death b	di noi resulti		indenying G	ause givi	en in Pait		1 🗆 1	-1		obably 4 Unknown
Reco	cete hes be page 2 sh	Completed									24a. Was autop		prior to death?	topsy findings available completion of cause of
			25. Was case referred to medicat						26 Place	e of Deat		2□No	1 Nes	2□ No
of Vita Physician:	is certific director,	To Be	examiner? 1⊠Yes 2□ No	Hospital:	ent 2 🗆 El	R/Outpatie	nt 3 DO	Oth	05		ome 5 ☐ Resi		ther (Spec	ofy) At Scene
	h. After thi funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry 2 y Year) 2	8b. Time o	of 2	Bc. Injun	k?		28d. Describe	how injury occi	urred	4
Vision	tor: A the fu	cati	2 Accident investigati 3 Suicide 6 Could not	bo	05	00:0	3"		Yes 2]No	28f. Location (ect	2110	
	efter death Director: A d in by the fa	Certification:	4 Homicide determine	28e. Place of Inj building, et	ury - At hom c. (Specify)	Si Si	dour)aU	K	1	City or To	wn, State)		was Roze
Dj' To the Hospitei or	within 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical C		Physician: To the best aminer: On the basis o and manner st	f examinatio									
To the	within To the comple	Me	29b. Signature and title of certifier		\cap	00	290	. Licens	e number			29d. Date sign	ned (Monti	h, Day, Year)
			Matu U	nonica	-18	Hel	167	.C.1	1.E.			July 7,	2005	5
	1		30 Name and address of person wh	1-A)140	allak?	11 Pe	Print)	reet	, Ba	ltim	ore, Ma	ryland	21201	
	St Regist		31. Date filed (Month, Day, Year)	1 2005 32. Refistr	rar's Signatu	" A	Goods	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/5, perFH C845 7/18/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:05 PM Mary G. Arkuszewski 2-e05 U /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** En Medical Center cial Security Number unk 6. Sex Hone Hrundel 9. Birthplace (State or Foreign Country) Kentucky 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F 69 Director 216-32-3638 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2♣ No Baltimore Anne Arundel Director Maryland ARKUSZEWS KE, Man 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 21225 12 Second Avenue or Items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th nd Mental Hygiene. markad othar than College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental Howard Dyer Dorothy Whitaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bel Air, Maryland 21014 Debbie Liupaeter / Daughter 814 Peppard Drive of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 7/13/2005 Baltimore, Maryland Cedar Hill Cemetery 4 □ Donation 5 ▼ Other (Specify) Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 romusery 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical s a consequent of **Examiner** DI COHO, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and a be detached for use as the burial-transit The law requires that the death certificate be executed neumonic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 XYes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t 1 🗌 Yes 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗸 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA Diractor: After this d in by the funeral di 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certified

Name and address of perso

31. Date filed (Month

GAV IRG

Yeer)

Hospital

who completed cause of death (Item 23a) (Type, Print)

D

301

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			1 - State Amend Item	State of Mar 29d per D	yland / Departure (1845)	ortment of 107/12/05 difficate of	lealth and bb Death			22612
	Physici	an	1. Decedent's Name (First, Middle, Last)	N	lae	Ande	rcon	2. Date of Death	25°, 2005	3. Time of Death 8:20 pnm
	/Medic		Anna 4a. Facility Name (If not institution, give s		iae		r Location of Deat		4c. County of De	
	Examin	er	38 East 6th Stre			Frede			Freder	
	Funeral		5. Social Security Number 6. Sex	7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign
Ľ.	Director		404-32-3316	M 201F	77 Yrs.	Worth's Days	Tiodis IVIII.	May 14,	1928 Ke	ntucky
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	ţō	Maryland Frederic	k	Freder	ick				1 XYes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28e-1 show other treumstic avent, the Medical Exactinate must be notified at	I Director	10e. Street and Number 38 East Sixth Str	eet		10f. Zip Code	21701	10	Og. Citizen of What (Country?
	death	nera	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S	pecify Yes or No-		nerican Indian,
980	urs after el', or Ite	by Funeral	1 ☐ Never Married 2 ☐ Married 3 【XWidowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ②XNo		o Alcan, etc.)	Specify: W	
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of wo	rkina	16b. Kind of Busines	s/Industry
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22	filed withi Hygiene, other then		17. Father's Name (First, Middle, Last)		Lau	ndry	18. Mother's Na	ne (First, Middle, M		DILIE
/lanc	should be find Mental his marked of	To Be	Thomas		Hicks		Dora	Gillan		nnson
Maryland 21215-0036	1 and 2 sho Health and Iom 27 Is m ather treums		19a. Informant's Name/Relationship (Ty, Martha Philpott/I						City or Town, State castle PA	
ore,	jes 1 a of Hea if item or othe		20a. Method of Disposition 1 Xeurial 2 Cremation 3 R	omough from State	20b. Place of Dispo cemetery, cre	matory or other pla	се)		20c. Location - City	
Ë	0 0		'4 □Donation 5 □ Other (Specify)	emoval nom State		e Cemete				, Maryland
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signatur of Funeral Service Agens		00706 1	2. Name and Addre Keeney & O6 Fast (ess of Facility Basford Church St	P.A. Fundar	eral Home	land 21701
			23a. Part1. Enter the disease, or complishock, or heart fallure. List only or	cations that caused th	ne death. Do not en	ter the mode of dyir	ng, such as cardia	or respiratory arre	est,	Interval Between
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	LXuilliiici	<u>_</u>	Sequentially list conditions,). Due to (or as a	consequence of):					
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate ease. Cause (Disease or injury	Due to for as a	consequence or).					
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.O. Box	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
<u>α</u>	The law requires that the d ite has been signed by the bage 2 should be detached		Part II. Other significant conditions con	ntributing to death but	not resulting in the u	Inderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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Re	The lav	Eo						autops perform	ned? death	o completion of cause of ? as 2 No
Vital	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one		
of V	Physician: this certific ral director,	To	1 Yes 2 No	fospital: 1 Inpatient		IL SE COA		lome 5 Reside	nce 6 Other (Sp	pecify)
		:lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo	ryat rk?]Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	tend leath tor: the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	y · At home, farm, st		1163 2 1140	28f. Location (St	reet and Number or	Rural Route Number.
οi	s after s after of Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	,,,		City or Town	, State)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of ner: On the basis of a and manner state	examination and/or in	th occurred at the ti	me, date and place opinion, death occ	a, and due to the caurred at the time, da	tuse(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the Ho within 24 I To the Fu completel	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mo	
			Milus.	MD) (DO	60417		July 11, 2	2005
	14		30. Name and address of person who co		ath (Item 23a) (Type.	Print)	ATTENDED TO THE OWNER.		- 82 × 75 × 100	21702
	10		Hemen Shah	650	Thomas	Johns	en by	Frede	vick me	21702
	Sta Regist		31. Date filed (Month, Day, Year)	Jana Hegistran	's Signature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. 2. 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** July. 2005 11:55 Randolph Boyd Kevin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Southern Maryland Hospital Clinton George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sax Days Funeral Months Hours XXM 2□F 219 48 2785 54 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9543 Nottingham Drive 20772 United States or Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status NYes 2□No Vietnam 1□Yes XX No 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Mechanic (Diesel); Painter 12 Automotive other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Fint: If item 27 Is marked of Paul Webster Powell Rozlyn Crockett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Boyd (Wife) 9543 Nottingham Drive, Upper Marlboro, MD 20772 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 ☐ Burial XX Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If eny injury or once. July 8, 2005 Lee Crematory Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final Priysician epsis D PE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Metastatic lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 🗆 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Coagulopast certificate has autopsy performed? 2□,No 1 ☐ Yes 2√√No Hospitel or Attending Physicien: 24 hours after death. Funeral Director; After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2X No 1 V Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1XXVatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 241 30. Name and address of pe cause of death (Item 23a) (Type, Print) 3 750 HOSSein Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

			For	State of Maryland /	Depa	rtment of He	ealth and I	_	_	ie.
			1 - State Registrar		Cer	tificate of D	Peath	1	ag. No2 0	5 22614
	Pnysici	an	1. Decedent's Name (First, Middle, Last) Maurice Elmer	Ba11				2. Date of Dea Month	Day Y	ear S. Time of Death
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deatl	JULY	4 200 4c. County of	
	Examin	eı	CIVISTA MEDICAL C			LAPLA			СНАЕ	RLES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign Country)
	Director			M 2□F 86	Yrs.			Nov 21		Washington DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	Maryland Charles	Wa	aldo:	f				1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number		•	10f. Zip Code		1	10g. Citizen of Wh	at Country?
	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show effeal Exart ar mast be motified at		2855 Shavors Roa	ad		2060			United	States
	r dea	Funeral	11: Islantal States	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
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-0	2 8 8		Wanda Ball (Wife)	oe, Print)		g Address <i>(Street</i> a Shavors				
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	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funeral Director: After this certific completely filled in by the funeral director,	edicai (29a. Certifier 1 Certifying Phys	ician: To the best of my knowled her: On the basis of examination	dge, death	occurred at the tim	e, date and place	e, and due to the o	ause(s) and man	ner as stated.
	the Hin 24 tha F	Medi	one)	and manner stated.		29c. License				(Month, Day, Year)
	7 × i		29b. Signature and title of certifier	Dance M	\bigcirc			4	7/V	105
	111		30. Name and address of person who co	mpleted cause of death (Itom 23)	a) (Tupo		5262		111	100
	511		SAMUEL J. KLETMAN				יי יייטייטר דו	ירי וויסאנו יחי		207//
	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signature		V RD. ICC	o veri t	+,WASHIN	UIUN, MD	ZU/44
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			For State Registrar	ite of Maryland		artment of H			iene •9. N 2 0 0 5	22615
	Physicia		Decedent's Name (First, Middle, Last)	Calv	in F.	Berry		2. Date of Deat		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street Union Memorial Hosp			4b. City, Town, or Baltim	Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex 220-12-5419 XXM 2	□ F 7. Age (In yrs. la	rst birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	^y •a/)926 B	Birthplace (State or Foreign Country) Oston, Mass.
	Maryland f show led at	or	Usual Residence of Decedent		Town or Lo					10d. Inside City Limits XXX Yes 2 □ No
	with the 1 3a or 28a- It be notifi	i Director	10e. Street and Number	Union Avenu		10f. Zip Code	1211	1	0g. Citizen of What	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If it it is a 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, the Madral Examiner must be notified a page.	by Funeral	1 Never Married XX Married	as Decedent Ever in U.S med Forces? WW TYYes 2 □ No WW Ves, Give ar or Dates:	II '	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	umerican Indian, Vhite, etc. White
Baltimore, Maryland 21215-0036	d within 72 ho jiene. ir than "netur ir e Madical I	Completed	15. Decedent's Education (Specify only highest grade com. Elementary/Secondary (0-12) 12	oleted) Illege (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired SINESS OW	during most of work d)	ing	16b. Kind of Busine Indep	endent
land	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Charles F. Berry				18. Mother's Nam Marian	e (First, Middle, P DeWolfe	Maiden Sumame)	
, Mary	and 2 sho saith and I n 27 Is ma		19a. Informant's Name/Relationship (Type, Pr Bonnie Berry (Wife)	int)			and Number or Aur venue Ba		, City or Town, Stat 21211	e, Zip Code)
imore	Pages 1 ment of He ent: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Germation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)		to/Was		ory 7/14	/05 I	aure1, M	D
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Division	To the Hospital or Attending Physicien: which 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation	Date of Injury (Month, Day Year) Place of Injury - At hor building, etc. (Specify)	28b. Time of Injury					r Rural Route Number,
Ō	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in		29a. Certifier 1 Certifying Physician	To the best of my know	viedge, death	occurred at the tir	ne, date and place,	and due to the ca	ause(s) and manne	r as stated.
	To the Ho within 24 To the Fu	Medical	(Check only one) 2 Medicel Examiner: Call one) 29b. Signature and title of certifier	n the basis of examinati nd manner stated.	on and/or inv	estigation, in my o			ate and place, and 9d. Date signed (M	
	•		30. Name and address of person who complete	ed cause of death (Item	M.D. 23a) (Type.	AT	24389	146	guly	7,2005
	/U Sta	te	Jennifer L. 31. Date filed (Month, Day, Year)	00	1. D.	Unio	n Mem	orial	Hospit	al, mD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#10e, perFH . G845 . //12/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Rag. N2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 07:30 P M **Physician** 2005 07 JULY /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore BALTIMORE City HOSPITAL OF If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 223-32-5897 Usual Residence of Decedent 1 ☐ M 2 🕱 F Yrs. Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Exercites must be notified at 28a-f shov 1 Yes 2 □ No Director more Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. D S 504 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Maryland 21215-0036 ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. The Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) d 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Na e/Relationship (Type, Print) 501 N 2501 Violet Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2005 Son + orest 22. Name and Address of Facility 21. Signature of Funeral Service Licensea SS Funeral Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMY 15CHEMIC MATH **Physician** CAR /Medical Due to (or as a consequence of): **Examiner** 10 CLON TOLY 124/5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medicai IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 🗆 Yes 2 🖾 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑ Onknown ANDERLY A MUTENSION 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After t 1 Natural Injury 5 Pending after death. 1 Yes investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE CAIMI FARMIZIO SINAI HOSPIMA 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 12 2005 State Registrar

BOOKER

KNOWN

amend item#5, perin, 6846, 875,05 in State of Maryland / Department of Health and Mental Hygiene For State Registrar amend item #26 PER verb 8845 certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frederick **Physician** Year 3100 MENS tOCK 0740M Jul 2005 /Medical 4b. City, Town, or Location of Deau.

ANN A POLIS

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye March 14, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death rundel Gen KOSP 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 91 Year Director 1914 Lima, Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits wat be notified at Directo Indiana 1√2 Yes 2 No Bartholomew Columbus 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2230 Sims Court #3 238 47203 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Ite 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No ģ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fuel Inspector Engine Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John Bloomenstock ၉ Margaret Bray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trau once. Maxine Bloomenstock Wife 2230 Sims Court #3, Columbus, IN 47203 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Garland Brook Cemetery 7/14/2005 Columbus, IN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Miller-Dippel, Inc. 6415 Belair Road; Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** vioselevotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medicai as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0006054 who completed we of death (Item 23a) (Type, Print) 645 America , MD IDNES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

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ř	7.	9		1 - Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg.	N2005	226 8 3. Time of Death
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		Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath	4c. County of Death	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr.		9 Righ	MORE place (State or Foreign
		Director		Usual Residence of Decedent	1 Z - Co - 2	5 Ma	ry land.
		aryland show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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		death with the Maryland ms 23e or 28e-f show	al Di	30971 Edgeword De. 19958	Tog.	Citizen of What Cou	ntry?
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	3036	in 72 hours after death with the Maryiar "natural", or items 23e or 28e-f show balleal Examiner must be notified at	by	3 □ Widowed 4 □ Divorced 1 □ Yes 2 No Specify:		Specify: W	rite.
	15-(be filed within 72 hours after tal Hygiene. d other than "natural", or ite avant, I'æ Modled Examine	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	orking 16b	o. Kind of Business/In	dustry
	212	ed with ygiene rer tha t, I'e.	Com	College (1-4or 5+) Manager	A	AA Insi	cance.
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant, IL & M. ODGS.	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Na Solution	ame (First, Middle, Maid	den Sumame)	
	lary	2 shoul and Me is mark	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	Rural Route Number, Ci	ity or Town, State, Zip	Code)
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M	Baltimore,	Pages nent of nt: If it ry or o		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)		Location - City or To	AILL MA
30	3alti	permit. Departminite importa any inju		21. Signature of Funeral Service Lickness of Facility		NION ME	21093
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		Physician		shock, or heart failure. Vist only one cause on each line. Immediate Cause (Final disease or condition	ic or respiratory arrest,		Approximate Interval Between Onset and Death
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	within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28a-f show Le M. dical Extrainer must be notified at	Funeral	11 Marital Status 12. Was	Decedent Ever in U.S	. 13. V	Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
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Mary			19a. Informant's Name/Relationship (Type, Prin						City or Town, State, Zi	p Code)
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	o the vithin 2 o the omple	Mec	29b. Signature and title of certifier	i ilialinei Stateu.		29c. License	number	290	d. Date signed (Month)	Day, Year)
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	in		30. Name an address of person who complete	d cause of death (Item 2	23а) (Туре, f					
	ĮU		Jaine Bolello 31. Date filed (Month, Day, Year)	M.) . (32 82. Registrar's Signatu	8 5		n Ave	5E; 7	DC 20	032
	Sta Registi		JUL 1 2 2005	late &	Good					

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. 2005 22621
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2. Date of Death
	/Medic Examir Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County o
	nyland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	the Ma	recto	MD Baltimore Woodlawn 1 Tyes 2X No 109. Street and Number 107. Zip Code 109. Citizen of What Country?
	23a or	al D	6413 Windsor Mill Road 21207 United States of America
980	ours after dea ral', or Itema Examiner ru	by Funeral Director	11. Marital Status 1
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23e or 28e-f show any fujury or other traumatic event, it is Madical Exacidities to institute the Indillian at Ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Inspector 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Inspector
and	d be file ental Hy ced oth c evant	To Be (17. Father's Name (First, Middle, Last) Andrew Pope Anita Thersa Crook
lary	2 shoul and Me is mark raumati	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
re, l	s t and of Health item 27 othar to		Andrew Stansbury 22 N. Synington Ave., Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
altimore,	t. Page tment o tant: If jury or		'4 □ Donation 5 □ Other (Specify) Baltimore-Washington Crem 07/11/05 Laurel, Maryland
Ba	Depa Impo any Ir		21. Signature of Funeral Scrice Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, I 8728 Liberty Rd., Randallstown, Maryland 21133
	Physician and /Medical expected the prijal-transit	Ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
O. Box 68	ath certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \ Yes 2 \ No 9 \ Unknown \ 23c. If yes, outcome of pregnancy 1 \ Live birth 2 \ Fetal death 3 \ Ectopic pregnancy 23d. Date of delivery 4 \ Pregnant at time of death 5 \ Other (specify) \ 9 \ Unknown \
JS, P.	ires that the de signed by the a d be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown
Records,	aw requir as been si 2 should l	Completed	Pne 314.0(4) C4 24a. Was an 24b. Were autopsy findings available
			autopsy performed? autopsy performed? 1 Yes 2 Yes
ž Ž	Physicla this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 Note Yes 2 Note Yes Ye
lon	nding P ath. r: After t e funera	atlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how injury occurred
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospita 14 hours Funeral tely filled	edical C	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the within 2 To the comple	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	, h		30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print) North Armada 1 1 2 3 4 1
	17		301 Hospital Drive Glen Burnie MM
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature

			1 - For State Ragistrar	State o	f Marylai		artment of F rtificate of		d Mental Hy	giene Reg. No 20	05	226	22
	Physic		Decedent's Name (First, Middle Brian Edwa		ner				2. Date of De. Month JULY	8, 200	Year 5	3. Time of 0448	Death
	/Medi Examir		4a. Facility Name (If not institution	on, give street and nur			4b. City, Town, o			4c. County	of Death		A M
9.*	Funeral	<i>38</i> 1.	NORTHBOUND ON F 5. Social Security Number	6. Sex	7. Age (In yrs.	iast birthday)	CROWNS\	If Under 24		th	ARUN 9. Birthp		or Foreign
	Director		219-17-7657 Usual Residence of Decedent	1 ∏ M 2□F	22	Yrs.	Months Days	Hours N	3/24/1	983	Cour	place (State of htry)	MD
nyfand	ehow ed at		10a. State 10b. County	/	10c. C	ity, Town or Lo	ocation				1	0d. Inside Cit	ty Limits
he Ma	8a-fe	ector		Arunde1	Cr	ownsvi]						1 🗆 Yes	2 📉 No
with t	3a or 2	i Dir	10e. Street and Number 919 Bargagni	Road			10f. Zip Code 21032			10g. Citizen of \	Vhat Cour JSA	ntry?	
1215-0036 within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-1 ehov other treumatic event, tre Medical Exacultur must be notified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Mar 3 Widowed 4 Divorces	12. Was Dece Armed Fo 1 Yes	2 💢 No 'e		Was Decedent of Hif Yes, specify Cuba	lispanic Origini an, Mexican, Pe Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rac Blac			
5-0 72 hou	nature dical E	eted	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	ation during most of	workina	16b. Kind of Bu			
N g	and Mental Hygiene. le marked other then " eumatic event, ine Me	Completed	Elementary/Secondary (0-12)	College (1	·4or 5+)	life.	DO NOT use retired ectricia	n	·		rak		
Maryland	ental F ked ot Ic ever	To Be	17. Father's Name (First, Middle, William Cal	,	ner			18. Mother's Diana	Name (First, Middle, Lynn	Maiden Suman Coff]	•		
Maryla 2 should	le mer		19a. Informant's Name/Relations			1		and Number or	r Rural Route Numbe	er, City or Town,	State, Zip	Code)	
_	Item 27 Item 27 other tr		Mr. William Dur 20a. Method of Disposition	rner / fat			sition (Name of matory or other place		rownsville	e, MD 21		wn State	
Fag B	nent of ent: If It ury or c		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				natory or other plac e Cremati		10/05	Stevensv			
Balt	Department of Importent: If I eny injury or one		21. Signature of Funeral Service	allas	MO13	364 1		ve SW G	Singleton len Burnie	e MD 210	Home	e P.A.	
/۱/ Ex	ysician Medical aminer	ner	23a. Part. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	aDue to (aused the deal ach line. TPE or as a consecutive as a co	quence of):	er the mode of dyir	g, such as care	diac or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
Box 68760, K	attending physician and I for use as the burial-transit	an/Medicai Examin	Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d.	or as a consec	ancy _]Ectopic pregnancy			23d. Dat	e of delive	ory	
P.O. Bo	by the tached	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□ Unkno	ant at time of c	leath 5□	Other (specify)			Moi	nth	Day Ye	ear
Records, P.O The law requires that the	been signed should be del	þ	Part II. Other significant conditi	ons contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I.		obacco use contr es 22No		ne cause of de ably 4 □Ur	
al Reco	lificate has be or, page 2 sh	e Compieted	25 Was and alread to make						1 Yes	rmed? c	eath?	psy findings ampletion of car	vailable use of
of Vital Phyelcien: T	direct	To Be	25. Was case eferred to medical examinar? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Oth		Death Check only or g Home 5 Resid		er (Specify	AT SO	CENE
ing in	deatn. ctor: After th y the funeral	ertification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation Tourn 7	1, Day Year)	28b. Time of Injury	V M 1□	/ at	28d. Describe h	ow injury occurr	COU	EES, OVER	Ut-
·= 5	n p	ertif	4 Homicide determ	ained 286. Place	ig, etc. (Specif	y)	eet, factory, office		City or Tow				MO
Dit.	ere He	edicai C	29a. Certifier 1 ☐ Certifyir	ng Physician: To the	best of my kno	owledge, de th	occurred at the tin	ne, date and pla	ALD RIVER	rauco/c) and ma	nner ac ct	ated	36 00
To the H	Within 24 no To the Func completely f	Medi	29b. Signature and title of certifie	The You	el X	W	29c. License O.C			date and place, a 29d. Date signed JULY	(Month, I	Day, Year)	
	10		30. Name and address of person	A. KOREI	L 111	PENN S	TREET, B	ALTIMOR	E,MARYLANI	D 21201			
	Sta Registr		31. Date filed (Month, Day, Year)	1 2 2005 ▶	egis r's Signa	ture J.	Gorde						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7AM HARDY MARIE FURR Jun 29, 2005 ear **Physician** Month /Medical 4b. City, Town, or Location of Death BALTIMORE 4a. Facility Name (If not institution, give street and number)

MARINER HEALTH CARE 4c. County of Death Examiner 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Martin 24, Year | Min. | Min. | Martin 24, Year | Min. | Martin 24, Year | Min. | Min. | Martin 24, Min. | Min. | Min. | Martin 24, Min. | Min. | Min. | Martin 24, Min. | Min 5. Social Security Number **Funeral** Birthplace (State or Foreign Coving GINIA 1 M 2 F 231-20-5067 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic avant, the Mudical Examiner must be notified at **BALTIMORE** MD Director 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 2617 E. CHASE STREET 10f. Zip Code or Itams 23g or 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married X Widowed 4 Divorced 1 Yes 2 No Black Baltimore, Maryland 21215-0036 þ Specify 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTUSA (MISS) EXAMINER 16b. Kind of Business/Industry **INSURACE** ges 1 and 2 should be filed within tof Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
RICHARD BEASLEY 18. Mother's Name (First, Middle Maiden Surgame) 19a. Informant's Name/Relationship (Type, Print) RONALD FURR Son 19b. Maijing Address (Street and Number of Plan Rough Number, City of 1921 3 state, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BALTIMORE, MARYLAND Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CONTROL OF OTHER TY 07/02/05 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral S 22. Name Miller SMETropolitan Chapel P.C. 1639 North Broadway Baltimore , Maryland 21213 23a. Part1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 PERTENSION 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed PARKINSON'S 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred To the Hospital or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funaral Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 30. NO GOTTORONANASOEASAR INBALITION (Item 23a) (Type, Print) STREET 153 NORTH BACTIMORE 71201 31. Date filed (Month, Day, Year) JUL 1 2 2005 Registrar

		1	For State Registrar	State of Maryland		artmen rtificat			nd Mer		ene 9. N <mark>2 () (</mark>)5	22624
Phys		ו	Decedent's Name (First, Middle, Last)	J FINK						Date of Death Month WY	Day 2	des-	3. Time of Death
Exar	edica mine		a. Facility Name (If not institution, give str					Location of			4c. County		
		- 5	NORTHWEST HOSPITAL Social Security Number 6. Sex	7. Age (In yrs. la	ıst birthday)	If Under	1 Year	STOWN	4 Hrs o	Date of Birth		9. Birth	place (State or Foreign
Funer Direct		3		^{1 2□ F} 81_	Yrs.	Months	Days	Hours	Min.	EC. 22,	1923		MD MD
pur		-	Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	ocation							10d. Inside City Limits
Maryla f sho		.	MD BALTI	MORE	BALT	IMORI							1 ☐ Yes 2 🖁 No
h the			10e. Street and Number			10f. Zip	Code			11	0g. Citizen of \	What Cou	•
ath wit		- Ta	4 ELM HOLLOW COUR		142	Was Dass	doot of L	2120		Vas or No-	14. Rad	e - Ameri	USA ican Indian,
be filed within 72 hours after death with the Maryland tala Hygiene. The state of other than "netural, or items 23a or 28a-f show event, If a Mcdical Exp. inter in after mailling a event, If a Mcdical Exp. inter in after mail and event, If a Mcdical Exp. inter in after mail and event.		2	1 ☐ Never Married 2 🂢 Married	. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give	5. 13.	If Yes, spe		Specify:	, Puerto Ric	y Yes or No- can, etc.)		ck, White	
hours tural',		ed by	3 Widowed 4 Divorced 15. Decedent's Education	Year or Dates:	16a. Dece	dent's Usu	af Occup	ation			16b. Kind of B	usiness/li	ndustry
in 72 .in "ne		plet	(Specify only highest grade	Completed) College (1-4or 5+)	`life.	DO NOT L	se retired	,	of working		TACHDA	NCE	
filed with Hygiene other the		Completed			INSU	RANCE	AGE		re Name (First Middle	I NSURA		
Mental Hyarked oth		To Be	17. Father's Name (First, Middle, Last) JOSEPH		FIN			PAUL	INE				GLATT
2 should and Men Is marke	2	f	19a. Informant's Name/Relationship (Typ					COUR			r, City or Town		
Health tem 27		-	JEANNE FINK / WIF 20a. Method of Disposition	20b. P	lace of Disp	osition (Na	me of		Dat	-	20c. Location		
Pages 1 ar nent of Hea int: If item ;	2		1 ABurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 25 ☐ Other (Specify)		INGTO				7/10/	/2005	BALT	IMOR	E, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if tiem 27 15 is marked other than "netural; or items 23a or 28a-f show any injury or other teamatic event. It is Marcal Examine in white notified a	once.		21. Signature of License		2	2. Name a	nd Addre	ss of Facifit	y SOL	LEVINS	SON & B	ROS.	, INC. MD 21208
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	n. Do not er	nter the mo	de of dyir	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
Medic Examin physician and the burial transit	ner transit	ledical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t		ge_	Du	non	ua				
The law requires that the death certificate the has been signed by the attending physical properties as the	for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	□Ectopic		y				ate of del	ivery Day Year
law requires that the tas been signed by the	oo de	þ	Part II. Dther significant conditions con	tributing to death but not res	ulting in the	underlying	cause gr	ven in Part	I.	23e. Did to			the cause of death?
has been sign	CA	Completed									rmed?	prior to death?	utopsy findings available completion of cause of
	rector, page	O	25. Was case referred to medical					26. Plac	e of Death	1 Yes (Check only o	2 10 16	, , , ,	
	0	To B	ovaminar?		ER/Outpati		JOA				dence 6 🗆 O		cify)
ding After	e funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time Injury		28c. Inju Wo 1 [ury at ork?]Yes 2□]No		now injury occi		
after des	d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm,	street, fact	ory, office		2	8f. Location (3 City or Tox	Street and Num wn, State)	nber or R	ural Route Number,
To the Hospitel or Attendation 24 hours after death To the Funerel Director:	completely filled in	edical C	29a. Certifier Certifying Physical Examination	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, de ation and/or	ath occum investigati	ed at the	time, date a opinion, de	nd place, a ath occurre	nd due to the id at the time,	cause(s) and r date and place	manner a	s stated. e to the cause(s)
To the	котр	Me	29b. Signature and title o certifier	7 N _ A.I				ise number	70		29d. Date sign	ned (Moni	th, Dey, Year)
r	\		107/4	w 3 MD			D	- D	O.		Tilley	4	, wos
1	8		30. Name and address of person who be	IMPERIAL	-,50	e, Print)) .	- D	445	05			
100	Sta	ite	31. Date filed (Month, Day, Year)	3 Registrar's Sign	or A	Service .							

		-	For State Registrar	State of Ma	aryland		rtment of F		nd Men	ntal Hygie Reg	ene . N2 0 0	5 22	625
	Physici		1. Decedent's Name (First, Middle, Last JOSEPHINE CARME		T.AR					Date of Death Month JULY	Day IZI.	/ear	of Death Q13 μΜ
	/Medic Examin	al -	4a. Facility Name (If not institution, give Saint Joseph	street and number)		ter	4b. City, Town, o		Death OWSOI		4c. County of		
	Funeral Director		009-22-0137	x 7. Age ☐M 2IXIF	e (In yrs. las 77	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2- Hours	4 Hrs. 8. Min. 3	Date of Birth (Month, Day, Y /23/192	(ear) 28 1	9. Birthplace (State Country) NEW YORK	e or Foreign
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside	City Limits
	Mary I-1 sh	to	MD BALTIMO	RE	Т	OWSON						1 🗆 Y	es 2 🛚 No
	th the	irec	10e. Street and Number				10f. Zip Code			100	g. Citizen of Wh	at Country?	
	ath wi	ral	8432 PLEASANT PLA				212		i-0.(0it-		USA 14 Bass	- American Indian,	
36	be filed within 72 hours after death with the Maryland stat Hygiene. The death state of the stat	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:		SI:	Vas Decedent of H Yes, specify Cub	Specify:	Puerto Rica	n, etc.)		White, etc. WHITE	
2-00	72 hou 'natura	Completed by	15. Decedent's Edi (Specify only highest grad			(Give	ent's Usual Occup kind of work done	during most	of working	16	6b. Kind of Busi	ness/Industry	
121	within ene. than "	Jdwc	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5	+)		00 NOT use retire MAMAKER	J)			OWN HOI	Æ	
102	Hygie other	Be Co	17. Father's Name (First, Middle, Last)			110		18. Mother	's Name (Fi	rst, Middle, Ma	aiden Sumame,		
ylar	2 should be and Mental Is marked o	To B	CRESZENCO D'APOI	JTE						D'ORIO			
Mar	d 2 shoth and the and the shoth should be shou		19a. Informant's Name/Relationship (7) GEORGE GISCHLAR/HI				g Address <i>(Street</i> PLEASANT				SON, MD		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic en		20a. Method of Disposition 1	Removal from State	DULA	netery, crem NEY V	sition (Name of natory or other pla ALLEY ME	M. 7	Date 7/13/2			ity or Town, State	
Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Licen:		e .		Name and Addre	ss of Facility	THE J	OHNSON	FUNERAL	L HOME, E 21286	P.A.
	Fnysician /Medical Examiner		23a. Farn. Enter the disease, or compended, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	lications that caused in e cause on each ir a. ACUTE Due to (or as	STR	OKE	er the mode of dyi	ng, such as c	cardiac or re	spiratory arres	it,	Approxim Interval E Onset an	etween d Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	ence of):							
8760,	icate be executed physicien and s the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):							
9	ertificat ling ph) e as th		IF FEMALE:	23c. If yes, outcome	of prognan	m,					22d Date	of dollars	
О. Вох	it the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3	Ectopic pregnanc Other (specify) _	<i>,</i>			Mont	of delivery h Day	Year
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Division of	al or Attendii s after death. al Diractor: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et			eet, factory, office		28f.	Location (Stre City or Town,		or Rural Route N	umber,
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	1		30. Name and agriress of person who	completed cause of	eath (Item)	23a) (Tune		4124			1110	100	
5	70			. M . D .	76.01		R DRIV	E. TO	WSON.	MARY	LAND a	21204	
	Sta Registi		31. Date filed (Month, Day, Year)		4B.O: .		fort		,				
	riegisti	-11	JUL	W 7000	THE PERSON NAMED IN	a"	5 8						

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Marshall Frederick Gilchrist JULY 6,2005 12:40A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adopting Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√**M 2□F Director 013-16-3163 83 Oct. 1 1921 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rel', or items 23e or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD **Baltimore Timonium** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2318 Springlake Dr. 21093 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Xes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced 'neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Defense Dept. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be to nent of Health and Mental I snt: If item 27 is marked of Joseph Gilchrist Maude Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2318 Springlake Dr., Timonium, MD 21093 Olga Rasmussen Gilchrist or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: If any injury or Balto. Wash. Crematory 7/12/05 Laurel, MD ^¹ 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bryan W. Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Clary 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOGENIC SHOCK /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit CORONARY ARTERY DISEASE Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown AMYLOIDOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL FAILURE autopsy performe 22 No VENTRICULAR ARRYTHMIA 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medicai Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7-6-05 LWT الادرى rad D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		For State Registrar	State of Man		partment of l ertificate of		nentai Hygiei Reg.	000	22627
Physic /Med Exam	ical	1. Decedent's Name (First, Middle ARE 4a. Facility Name (If not institution)	s WESI	Ey (TREEN	,	2. Date of Death Month	Day Year	3. Time of Death
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USO urs after al', or ite	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	or in U.S.	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify:	
1215-U	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5+)	(G	e. DO NOT use retir	e during most of wor		Kind of Business/ ABC	
Maryland 2 d 2 should be fited th and Mental Hygi T is marked other treumstic avent, I	To Be C	17. Father's Name (First, Middle Charles	Pittman	10h M	ailing Address (Stra	ElizA	ne (First, Middle, Mai LAFTA eral Boute Number, C	WAShi	nortan
- C - N -		19a. Informant's Name/Relation 20a. Method of Disposition 1 V Burial 2 Cremation	DAKELL	30 20b. Place of Di	sposition (Name of crematory or other pi	1gin	AVE. /S	Location - City or	H 2/216
Baltimore, permit. Pages 1 a Department of Hei Importent: If item any injury or othe	. Kilki	*4 □ Odnation 5 □ Other (Specify)	Wood	Awn Cen 22 Name and Add 12 ARS	ress of Fatality	114/05 E	Atto. F	un. Ster
Physiciar	1	Immediate Cause (Final disease or condition	or complications that caused that only one cause on each line.	e death Do not	enter the mode of d	ying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
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To the I within 2. To the I complet	M	29b. Signature and title of cease	J. M. M.	D .	29c. Lice) 0054	9 1 290	Date signed (Mont	th, Day, Year) - 2005
3		30. Name and address of pers). Brich	2401	W. Delve	ident A	ve. BAH	imone r	ND 21215
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		1- State of Maryland / Department of Health and N Certificate of Death	vientai Hy	
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/Medica		Iona Grace Harris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death.
Examine	ę,	Flanklin Square Hospital Rosedalt	2	Bo-1+1M6re
. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of B	irth ay, Year) 9. Birthplace (State or Foreign Country)
Director.		Usual Residence of Decedent	7-13-19	951 Md
laryland show		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
the Man 28e-f sh	ctor	Md N/A Balto		1X Yes 2 □ No
ath with the Maryla 23e or 28e-f shoust be recilified at	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
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036 urs aft	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Yes 2 ☑ No Specify:		Specify: Black
1215-0036 within 72 hours after death with the Maryland one. then "neturel; or flems 23e or 28e-f show he Macietal Exercitivation and the mailtimed at	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	kina	16b. Kind of Business/Industry
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arylar S should be and Menta is marked eumatic e	1	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Run</i>		
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Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe page.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
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Balt Balt Departit Import Impo		21. Signature of Funda Service Licensee 22. Name and Address of Facility		F/H West
_ 20200		12 10 119 11 11 11 11		venue Balto, Md 21215 Approximate
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Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Breast concer With Met Due to (or as a consequence of):	0>16	->15
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		► 4 Mmes 06(337		7/10/05
X		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	1
		Dr. Kirmoni Ahmed Gloso Franklin Square prive	ba 1+	imore MD 2/237
State Registra	3	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
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		Registrer				Ce	rtificate of	Death		<u> </u>	5	
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/Medic		MARIE		HINES					July	09 200		1:40 a ^M
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Funeral Director		219-26-8265	1 □ M	2XX	69	V	Months Days		(Month, Day,) FEB. 06			lace (State or Foreign itry) RYLAND
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items	Funeral	11. Marital Status		Armed Ford		S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- America , White, e	an Indian, etc.
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2 sho and is ma		19a. Informant's Name/Re	elationship (<i>Type</i> ,	Print)		19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Number,	City or Town, S	itate, Zip	Code)
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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at one.		21. Signature of Funeral	La Licanses	1_	_	W		BROWN CO. RI'H AVENU	MMUNITY F	UNERAL	HOME	E P.A.
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s afte state or state or	Certification:	4 Homicide		buildin	g, etc. (Specify	′)			City or Town,	State)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only 2 N	ertifying Physici ledical Examiner	en: To the to On the base	sis of examina	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and man e and place, ar	ner as stand due to	ated. the cause(s)
omple	Me	29b. Signature and title of	certifier					se number	29	d. Date signed	(Month, i	Day, Year)
/		DIA10	10110	1,11			DS	8303	ل	504	9 8	005
		30. Name and address of	person who comp	leted cause	of death (Item	23a) (Type,	Print) Proc	les St	DOTALIN	(w	2125).4
Sta		31. Date filed (Month, Day	v, Year)	32.	gistrar's Signa	ture	Sant a	-, 0,	, = = = = = = = = = = = = = = = = = = =			/
Registr	ar	JU!	1 2 2005	130	ever 1	U 19						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

1/1/05 / Mariellen. Fine 1,700

Division of Vital Records, P.O. Box 68760,

			1 - For Amend Item 8 Registrar	State of M	3743 nd /12ep	ertreent of H tificate of I	lealth and Death	Mental Hy	giene Reg. N <u>2</u> . 005	_22630
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death
	/Media		Georgeanna			Hubba	ard	July	06 200	
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Dea	th	4c. County of De	ath
			Joseph Richey H 5. Social Security Number 6. Sex			Baltin	nore If Under 24 Hrs	2 Data of Bio		
П	Funeral Director			M 217 F	e (In yrs. last birthday) 80 Yrs.	Months Days	Hours Min	Month, Da	1-1924	irthplace (State or Foreign Country)
			Usual Residence of Decedent		80			12 02	24	VA
	yland yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maried S	tor	MD NA		Baltimon	ce				Yos 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
	23a usit b	ai	3412 Powhatan A	ve 2nd	Floor	212	216		U.S.	Α.
	tams tams	Funerai		2. Was Decedent Armed Forces?	Ever in U.S. 13. V	Was Decedent of H	lispanic Origin? (San, Mexican, Pue	Specify Yes or No		nerican Indian,
36	ours after death with the Marylan ral', or itams 23a or 28a-f show Examiner must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give X X	No .	1□Yes 2□No	Specify:		Specify:	
5-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show itsal Examinar must be notified at	d be	3½ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Occup	ntion		16b. Kind of Busines	Black
5	⊂ 2 2	Completed	(Specify only highest grade	completed)	(Give	kind of work done of NOT use retired	during most of wo	orking	Baltimor	,
2121	y within piene. r than "	E O	Elementary/Secondary (0-12)	College (1-4ors	5+)	Teache	er		Public S	-
	be filed vital Hygiend of the filed very evant, It	0	17. Father's Name (First, Middle, Last)		<u> </u>			me (First, Middle	, Maiden Surname)	0.11002.5
Maryland	2 should be a nand Mental I is marked o raumatic eva	To B	Clarence Jones				Annie	Maith		
lan	and and is m		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or F	lural Route Numb	er, City or Town, State	, Zip Code)
	s 1 and 2 f Health itam 27 other tr		Annie Marie Jac	kson-Si			an Ave		more, Md	21216
ore	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location - City	or Town, State
Ë	nit. Pag artment ortent: I injury o		`4 ☐Donation 5 ☐ Other (Specify)		Garrison	n Forest	: Vet.	7/14/0	Owings	Mills, Md
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service License	°CLA	Mã	Name and Address	ss of Facility H West	20 325000		
	40340		- Mannon	\gg 1710					imore, Ma	
			23a art1. Enter the disease, or shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	ine.	er the mode of dyin	ig, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	la	rama	7 the	Lung			10 months
	Examiner			Due to (or as	a consequence of):	1.00	:0			
	Mark 1	Je.	Sequentially list conditions, if any, leading to immediate		a consequence of):					
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							ķi.
o,	an ar		resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai	€ d							
9	ertific ling p	Mec	IF FEMALE:							
Вох	eath certifi attending I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	1		23d. Date of d Month	lelivery Day Year
o.	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)				,
<u>α</u>	that I		Part II. Other significant conditions con	tributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Records,	uires sign lid be	d by						10	Yes 2,2 No 3 □	Probably 4 Unknown
00	w require been signated should b	iete						24a. Was	an 24b Were	autopsy findings available
Re	The iaw requires that the death certifi rate has been signed by the attending page 2 should be detached for use as	Completed						auto	psy prior to prmed? death	o completion of cause of
Vital		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes		es 2□No
\geq	ys diis	To B	examiner?	ospital:	ent 2 ☐ ER/Outpatien	at 3 DOA Oth	OF.		dence 6 SOther (S)	pecify Hospicz
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ury 28b. Time of Injury	28c. Injur	y at	-	how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	tandir death. tor: Al	atic	2 Accident investigation				Yes 2 □ No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	urs al									
	Hosp 24 ho Funa funa tely fi	Medical	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	er: On the basis of	of my knowledge, death of examination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	Mec	29b. Signature and title of certifier	and manner st	ardu.	29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
	F 3 F ŏ	1/	No. R	nedich	20.5	200	8582		07/07/05	
1	21/		30. Name and address of person who co		death (Item 23a) (Type.		0,03		VT 107/05	
V			150 W, Lanvale It	Buch		21217-	4120			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	Annal 1	77.0			
	Registi	rar	JUL 12	2000	الكر متانيكاليا	ASTA STORY				

		_	For State	State of I	Maryland		rtment of F		d Mental Hy	giene	005	22621
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		061	lineale of	Dealii	2. Date of D	144	000	3. Time of Death
	Physicia		Hattie	,	Gib	bs	H	lenry	July	O8	2005	2:25a. M
	/Medic Examin		4a. Facility Name (If not institution, gr	ve street and numbe			4b. City, Town, o				County of Death	z:ZJa.
	LXamii	٠.	Bon Secours Ho	spital			Baltim	ore				
	Funeral			Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B	irth	9. Birthi	place (State or Foreign
н	Director		577-30-3828	1□M 2XXX	81	Yrs.	Montais	110013				SĆ
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	MD NA		Bal	timor	е					1 XYes 2 □ No
	r 288	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	38 O		1928 West Lexi	naton S	troot		21	.223		11	J.S.A.	J
	death	ner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13. \		lispanic Origin'	? (Specify Yes or N		4. Race - Ameri	
90	or Its	by Funeral	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2[If Yes, Give			☐ Yes 2 No	Specify:	dono rucan, etc.)		Black, White, Specify:	etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23s or 28s-f show ha Madical Examiner must be notillised at	D D	3 Widowed 4 □ Divorced	Year or Date	s:						B.	Lack
<u> </u>	in 72 "nat	Completed	15. Decedent's l (Specify only highest g	rade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind	d of Business/In	ndustry
712	iene.	mo	Elementary/Secondary (0-12) 11th grade	College (1-40 na	or 5+)			· .	perator	Ara	Food	Service
	filed I Hyg otha	Be C	17. Father's Name (First, Middle, Las					· · · · · · · · · · · · · · · · · · ·	Name (First, Middle	e, Maiden S	Sumame)	
la	uld be Aenta rkad tlc ev	To B	Bonnie Burton					Harri	ett Bur	ton		
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street	and Number o	r Rural Route Num	ber, City or	Town, State, Zij	Code)
	and ealth m 27		Valerie Henry-	-Daughte	r			xingt				Md 21223
altimore,	ges 1 r of H if Ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta	ite Cé	ametery, cren	sition (Name of natory or other pla		Date		ation - City or T	
Ë	. Pag tmen tant: jury		`4 Donation 5 Other (Spec	eify)	Gar				7/15/0	5 Owi	ngs Mi	ills, Md
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Once.		21. Signature Funeral Service Lic	ensee	res	$) \qquad \stackrel{Ma^{22}}{43}$	Name and Address Ch F/F	f West ash Av	e, Balt:	imore	, Md	21215
			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	nplications that cause on each	sed the death	. Do not ent	er the mode of dyir	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Carron	i noma	d the	Luna				Onset and Death
	/Medical Examiner	- 4	resulting in death)	Due to (or	as a consequ	ience of):	-	3				
	Laminer	ų.	Sequentially list conditions,	b. — Due to (ex	as a consequ							
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury	D00 10 (01	as a consequ	ierica or).						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ience of):						
68760,	e be	dicai		d								
		a										
Box	death certifii e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregna 1 2 □ Fetal		Ectopic pregnanc	v		23	3d. Date of deliv	,
.O.	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		t at time of de		Other (specify)	, 			Month	Day Year
<u>P</u> .	faw requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions	contributing to don't	h but not ross	ulting in the u	adorhina onuna au	es is Bort I	23a Did	tabassaus	o contributo to t	the cause of death?
S,	ires tha signed	by		contributing to deat	n Dut not lest	intarigram tries di	idenying cause giv	en in Fait I.				bably 4 Unknown
20.2	w requir been si should	ompleted	- Wyunia									
360	Ф <u>г</u> <u>в</u>	m			* "					s an opsy formed?	prior to co death?	opsy findings available empletion of cause of
<u></u>	ician: The t certificate ha ector, page	င္ပ	25. Was case referred to medical						1 ☐ Yes	2₹ No	1 🗆 Yes	2 No
Ξ		o Be	examiner? 1 Yes 2 No	Hospital:	atient 2	EB/Outpation	t 3 DOA Ott		Death (Check only ng Home 5 2 es		Other (Once	4. 1
0	ding Phys h. After this funeral di	H	27. Manner of Death	28a. Date of I	njury	28b. Time of			28d. Describe			(9)
ion	Attending r death. actor: After	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		Day Year)	Injury		rk? Yes 2 □ No				
Division of Vital Records,	i or Attend after death Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could not determine	d Zee. Place of	Injury - At ho		eet, factory, office			(Street and own, State)	Number or Run	al Route Number,
	urs aff raf Di											
	To the Hospital or Attaining 24 hours after de To the Funaral Directo completely filled in by the	edical	29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex	Physicien: To the be aminer: On the basi	s of examinat	wledge, death tion and/or in	occurred at the tile vestigation, in my o	me, date and p opinion, death o	place, and due to the occurred at the time	e cause(s) a e, date and p	and manner as s place, and due t	stated. to the cause(s)
	o the ithin 2 o tha mple	Med	29b. Signature and title of certifier	and manner	siated.		29c. Licens				signed (Month,	
)	F 3 F 8	V		3	30. 5-				0.72			
	IXP		30. Name and address of person wh		of death (Item	23a) (Type		<u>00 85 8</u>			105	
		G.	30. Name and address of person where the second sec	DICT.	150 W	Lan	uma si	. BAL	timers .	me 2	12/7	
	Sta		31. Date filed (Month, Day, Year)	32. Reg	arar's Signa	ture	backer	, 100,0			! !	
	Regist	ar	JUL 1	2 ZUUS	16 10 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	15						

			1 - For State Ragistrar		of Marylan	-	artment rtificate			and M	F	lag. 2.0 () 5	2263	2
П	Physici	an	Decedent's Name (First, Midd			-					2. Date of Dea Month		005	3. Time of De	
	/Medi	cal	Willene	C1a:		Lt	ngram		l acation o	4 Death	Ju1y		005 ty of Death	1620	М
	Examir	ier	4a. Facility Name (If not institution Anne Arunde1	-				apo1		rDeam			e Aru		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under		8. Date of Birtl			nplace (State or F untry)	oreign
	Director		226-36-0443	1 □ M 2XXF	89	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day May 25	, 1916	Ida	ho	
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c Cit	ty, Town or Lo	cation							10d. Inside City I	imite
	daryk 1 sho	ō		Arunde1		Crowns								1 Tes 2	
	28a-	rect	10e. Street and Number			o Lowing .	10f. Zip (Code				10g. Citizen of	What Co		21
	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show liteal Examinar must be notified at	Funeral Director	1448 Fairfiel	d Loop Ro	oad				032				SA		
	death	ner	11. Marital Status	12. Was D	ecedent Ever in U Forces?	.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ice - Amei	ncan Indian,	
98	or Ita		1 Never Married 2 Ma	rned 1 ☐ Ye	s 2 XNo Give		1 ☐ Yes 2		Specify:	, 1 00110	ritodri, etc.)	Spec		White	
21215-0036	72 hours "natural", dreal Exc	ed by	3 X Widowed 4 ☐ Divorce	d Year or	r Dates:										
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212		шо	Elementary/Secondary (0-12)	College	e (1-4or 5+)	Posta	al Car	rier	:			Post	Offi	ce	
	be filed tal Hygie d other avent, III	Be C	17. Father's Name (First, Middle	, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Suma	me)		
<u> a</u>	D 6 8 0	To	William Squib	b						nkno		Wann			
Maryland	2 sh and la m		19a. Informant's Name/Relation								I Route Numbe			îp Code)	
	s 1 and f Health itam 27 othar tr		Virginia L. C	urtin (Da		8800 Place of Dispo			og Al		Easton			Favor Chat-	
Baltimore,	0 0		1X Burial 2 ☐ Cremation		m State	cemetery, crer	natory or oth	ner place	1			20c. Location			
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Ba	permit. Departn Imports any inju		12-2.	he-			Harde	sty	Fune	ral i	Home, P	.A.	л 21	401	
	<\$*		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	at caused the deat	h. Do not ent							<u> </u>	Approximate Interval Between	
	Physician		Immediate Cause (Final	t only one cause of	ii eacii iii e.									Onset and Dea	
	/Medical		resulting in death)	se or condition ng in death) Due to (or as a consequence of):											
	Examiner		Sequentially list conditions,	b	yo Car	diel	mt	arc	10	~				min.	
7	ed ssit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d Due t	to (or as a conseq	uence of):	7/10	40						min.	2
Λ	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due	to (or as a conseq	uence of):	i vi w	() OY						juis	
8760,	e be e sician b burià	cai E		1 (1	nonau	4 91	flux	al	Lak	a	~				
9	law requires that the death certificate I as been signed by the attending physi 2 should be detached for use as the I			0			1 0								
Вох	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pre	anancy				23d. D	ate of deli	very	
	ne deat the att hed for	sicie	in the past 12 months? 1 Yes 2 No		egnant at time of d		Other (spe					М	onth	Day Yea	ſ
P.0	that the di ed by the detached	Phy	9 Unknown		Part of the same o		- 4 - 1 -				an- Dida-		4.21 4.11		
g,	ires that signed t d be det	i by	Part II. Other significant condit	100 mal	dealin but not res	Title	nderlying cal	l, n	10	order		1		the cause of deat	
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Rec	9 4 9	id III	file morally 1	yperte	- long	Dorce	Jones.	105/	,		24a. Was a autop: perfor	sy	prior to o death?	opsy findings ava ompletion of caus	lable e of
Vital Records,		e Co	25. Was case referred to medical	gain					00 Di	-f D	1 Yes	2 2 No	1 🗆 Yes	30 No	
		o B	examiner?	Hospital:	□Inpatient 2 🖎	ER/Outpatier	nt 3 DOA	Othe	~		<i>(Check only or</i> ne 5 ☐ Resid		her (Spec	ifu)	
J Of	g Phys ter this neral di	I.	27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time of Injury		c. Injury Work			28d. Describe h			"))	
Division	Attending Ph r death. actor: Alter th by the funeral	Certification:	2 7100100111	tigation		injury	М		es 2 🗆 l	No					
Ξ	or Att	ıţį.	3 Suicide 6 Could 4 Homicide deten	mined 286, Pla	ace of Injury - At ho ilding, etc. (Specif	ome, farm, str	eet, factory,	office		4	28f. Location (S City or Tow	treet and Num n, State)	ber or Rui	ral Route Number,	
	Hospital of hours at Funaral D		20-0-4	Di											
	To the Hospital or Attenwithin 24 hours after deati To the Funaral Diractor: completely filled in by the	edicai	29a. Certifier 1 Certifyi (Check only 2 Medice	ng Physician: To the Exeminer: On the and m	the best of my kno basis of examina anner stated.	wledge, deati ition and/or in	n occurred at vestigation, i	t the time in my opi	e, date and inion, deat	d place, a th occurre	and due to the c ad at the time, c	ause(s) and m late and place	anner as , and due	stated. to the cause(s)	
	To the within 2 To tha complet	Me	29b. Signature and title of certifi				29c.	License	number	/	2	9d. Daţe sign	ed (Month	, Day, Year)	
	->-0		· nul	mae	no		100	06	186	4		7/11/	10		
	. n		30. Name and address of person	who completed ca	ause of death (Item	n 23a) (Type,	Print)	111	A C.	711	mp 2	1188			
	12		8601 Vetgan	o that	- Way	STELL	CVU	100	NIV	ing	m) 2	1100			
	Sta Registi		31. Date filed (Month, Day, Year JUL 1	2 2005 32	Redistrar's Signa	ture A	Carle)	,							

			State of Mary		rtment of Health and N			22622
			Registrar	Cer	tificate of Death	Reg	2005	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	. 		July 4,	2005 Year	3. Time of Death
	/Medic Examin		Patricia Johnso 4a. Facility Name (If not institution, give street and number))[]	4b. City, Town, or Location of Death	bury 4,	4c. County of Death	10.00F
	LAGIIIII	CI	Laurel Regional Hospita	ıl	Laurel		Prince G	eorges
	Funeral			n yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
	Director		577-44-1744 1 M 2 X 7	1 Yrs.		Sept. 1	4,1933	place (State or Foreign ntry) D.C.
	land ow		the second secon	Oc. City, Town or Loc	cation			10d. Inside City Limits
	Man a-fsh	tor	Md. Anne Arundel	nnapoli	5			1X Yes 2 □ No
	or 28)ire	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?
	s 23a	rai	1319 Washington Drive		21403		JSA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or liems 23a or 28a-f show other traumatic event, the Medical Exam intrinative routified at	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☎ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	İ	Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Bla	etc.
21215-0036	"natural	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupation kind of work done during most of work DO NOT use retired)	sing 16	6b. Kind of Business/Ir	ndustry
72	within ene. then "	дшс	Elementary/Secondary (0-12) College (1-4or 5+)	Teacl	·	- F	Education	
	illed Hygid other ent,	Be Co	17. Father's Name (First, Middle, Last)	Teaci		e (First, Middle, Ma		
ılan	should be and Mental s marked o umatic eve	To B	Dennis Hardy		Ira Mc	Garrah		
Maryland	2 sho and I Is me		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rui		•	o Code)
	1 and 2 Health tem 27		Elaine H. Matthews(Sist	20b. Place of Dispos	9 Goose Pond C		C. Location - City or T	ioum State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 Cremation 3 Removal from State 44Donation 5 Other (Specify)	cemetery, cren	natory or other place)			
Ħ	nit. P vartme ortan injuri		21. Signature of Funeral Service Licensee		Mem.Cem. 7/12 Name and Address of Facility Tra		itland,M	aryıand
m	Deparenti Deparenti Imporenti any ir		Jen 9/ ener		12 Third St.N.			01
			23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.					Approximate Interval Between
5	Physician	6 7	Immediate Cause (Final disease or condition resulting in death) aMetasta	tic Pan	creatic Cancer			Onset and Death
	/Medical Examiner		Due to (or as a c	consequence of):				
	100	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a condition)	consequence of):				
	outed ansit	Examiner	cause. Enter Under vin Cause (Disease or injury that initiated events c.					
Ó,	e exection ar		resulting in death) Last Due to (or as a c	consequence of):				
58760,	icate be executed physician and s the burial-transit	edicai	d					
_			IF FEMALE: 23c. If yes, outcome of	pregnancy			23d. Date of deliv	renv
. Box	death certi e attending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 1 1 1 1 1 1 1 1 1 1		Ectopic pregnancy Other (specify)		Month	Day Year
P.0		hys	9 ☐ Unknown					
Ś	J. 90	ρχ	Part II. Other significant conditions contributing to death but I Hypokalemia	not resulting in the ur	nderlying cause given in Part I.		acco use contribute to	
Record	w require been sig	ompieted	пурокатешта			1 🗌 Yes	Λ	
Rec	has has	mpi				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medical		26 Plane of Dea	1 ☐ Yes 2. th (Check only one		2 No
	S S :	O B	examiner? 1 ☐ Yes 2 X No Hospital: 1 X Inpatient	2 ER/Outpatien	Other		ce 6 Other (Spec	ify)
n of	tei lei	uc:	27. Manner of Death 1 SNatural 5 Pending (Month, Day Y	28b. Time of	28c. Injury at Work?	28d. Describe how	v injury occurred	
sio	Attending ir death. actor: After by the fune	cati	2 Accident investigation		M 1 Yes 2 No	006 1		
Division	al or Attendir atter death. I Diractor: Af d in by the fu	Certification:	4 Homicide determined 28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office	City or Town,	et and Number or Rui State)	al Houte Number,
	spital	aC	29a. Certifier 1 X Certifying Physician: To the best of	my knowledge, death	occurred at the time, date and place,	, and due to the cau	use(s) and manner as	stated.
	To the Hospital or a within 24 hours after To the Funeral Dirac completely filled in E	edical	(Check only one) 2 Medical Exeminer: On the basis of example and manner state	kamination and/or inv d.	vestigation, in my opinion, death occur	rred at the time, dat	e and place, and due	to the cause(s)
	with To I	2	29b. Signature and title of certifier	•	29c. License number		d. Date signed (Month	Day, Year)
	01/8		Jany Dell	<u> </u>	0053235		1/6/03	
	D'		30. Name and address of person who completed cause of dea Daryl Hill, 13635 Ball			Mana 1 3	1 20707	
	Sta	ite	21 Date filed (Month Day Year) 22 December 21	Signatura	Ave., Laurel, I	waryıano	1_20/07	
	Registi		JUL 1 2 2005	ver St.	Goerle			

amend items#18,19a-b, perFH, 6845, //12/05 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:00 P M 2005 MORRIS KAUFMAN JULY /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
AUG. 17, 1 JEWISH CONVALESCENT CENTER BALTIMORE Birthptece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F Director 065-36-0247 87 1917 POLAND Usual Residence of Decedent 10d. tnside City Limits 10a, State 10c. City, Town or Location show 10b. County ust be notified at 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4303 CRESTHEIGHTS ROAD 21215 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, ir than "natural", or items the Medical Examiner m 11. Maritat Status Btack, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: WHITE 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) **GARMENT** 12 TAILOR other 27 is marked othe traumatic event, Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) Gottlieb 17. Father's Name (First, Middle, Last) Be KAUFMAN FRYDA COHL TER CHAIM ဂ္ Rsther KAUFMAN / SON Rural Boy Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 20058. 1 Burial 2 Cremation 3 Removal from State 07/10/2005 RADOMER VEREIN CEM. ROSEDALE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of **F**uneral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Onset and Death Immediate Cause (Finat disease or condition ZHEIMERS Physician /Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial-1 Box 68760. physician Physician/Medical the as attending p IF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No о О the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther, significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Denknown ENSIDN 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 2 12 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | tnpatient Other: P 1 Yes 2 No 3□ DOA ursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 11-Natural 5 ☐ Pending 1 Yes 2 No investigation death 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital LIF Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier E mo 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/2/208 CAKHAMI 7ASNEEM 7220 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

ORIGINAL

			For State Registrar	State of Maryland		rtment of H		-	giene	005	22635
	100		Decedent's Name (First, Middle, La.	st)				2. Date of De	ath		3. Time of Death
	Physicia		MARGIE	DESSIE		10	DWICK	Month	Day	Year 7.00	5 17:35 M
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death	1 10 100	4c. C	county of Deat	
		U	THE ZUHOZ 3HT	KINS HOSPITA	L-	BALTIN		CITY		NA	
	Funeral Director		00279-4881	ex 7. Age (In yrs. last	t birthday) _ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Loc	cation		-			10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show	tor	WV GRAI	T PE	TEA	SBURE	2				1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	71 1 2	1 -1	10f. Zip Code	,		10g. Citize	en of What Co	untry?
	23e o		HC 32 B	0× 172		268	47			0.5.	A·
	ams	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Si	pecify Yes or No Rican, etc.)	- 14	4. Race - Ame Black, White	
36	ges 1 and 2 should ba filed within 72 hours after death with the Marylan 1 of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Mydical Examination in the invitible of a content traumatic event, the Mydical Examination in the invitible of a	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give		☐Yes 2X No	Specify:			Specify:	(1.
21215-0036	hours tural'	q pa	15. Decedent's Ed	Year or Dates:	16a Deced	ent's Usual Occup	ation		16h King	d of Business/	HILE
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	a filed al Hygi I other vent,	BeC	17. Father's Name (First, Middle, Last,				18. Mother's Nam	ne (First, Middle	Maiden S	umame)	
ylaı	Ments Ments arked atic e	To	GEORGE GAZ	BRIEL JUDY			1-LOR	ENCE	Ki	MBL	E
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Z	Zip Code)
	1 and Health Im 27 Iher t		20a, Method of Disposition	20h Plac	a of Disnos	Sition (Name of	IERS "	Date O	200 100	ation - City or	MD: 21015
יסר	Pages nent of H int: If Ite		1 Burial 2 Cremation 3	Removal from State cem	etery, crem	natory or other place) = JUL	18	104		VILLE 1024
Baltimore			 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Liget 		7/7/	Name and Addres	ss of Fadility	COS	The	1917 A C	S. COM
Ba	permit. Departi Importi any inj		1 Thomas	Alexador	, 5	KAKI	AFH.	BAC	17 1	41	2/724
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest;		Approximate Interval Between Onset and Death
썙	Priysician		Immediate Cause (Final disease or condition resulting in death)	a BESPIRATO	RY	FAILUR	32				3 days
	/Medical Examiner		Tosuming in death)	Due to (or as a consequen							
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	utad d ansit	Examiner	ri any, leading to intribudate cause. Enter Underlying Cause (Disease or injury that initiated events								
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Вох	death certific e attending p ed for usa as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de	ath 3	Ectopic pregnancy			23	3d. Date of del Month	ivery Day Year
0.	0 0 0	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□ Pregnant at time of deat 9□ Unknown	in 5∐	Other (specify)			,		
<u>α</u>	requires that the de been signed by the a hould be detached t	/ Ph	Part II. Other significant conditions	contributing to death but not resulti-	ng in the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
ds,	sign d be	d by						10	Yes 2	ĺNo 3□Pr	obably 4 Unknown
Vital Record	w requ	Completed						24a. Was	an	24b. Were au	stopsy findings available
Re	The law ate has b page 2 s	дшо							osy rmed? 22 No	death?	completion of cause of
tal		e e	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110
f V	ysic lis ce dirac	To B	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Ninpatient 2 EF	VOutpatien	t 3 DOA Oth	er: 4 🗌 Nursing H	ome 5 🗆 Resi	dence 6	Other (Spe	cify)
n of			27. Manner of Death 1 ★ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury	occurred	
sio	tendi eath. or: A tha fu	cati	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □ No				
Division	nl or Attending P after death. I Director: After t d in by tha funera	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,
Ш	pital		29a. Certifier 1 Certifying Pl	nysicien: To the best of my knowle	adne death	occurred at the tir	ne date and place	and due to the	causa(s) a	and manner as	stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		miner: On the basis of examination and manner stated.							
	ithin ompl	¥	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
			Tracy / Wannie	MEDICAL DOCTO	OR	RE	S-00C)	Zoni	E (04	,2005
(11/		30. Name an address of person who	completed cause of death (Item 2	3a) (Type,					BALTIV	
1)		TRACY WARMER, TH	TOPAS HOPOUS	9271	Tel-Con	siolatis w	NEU STÉ			LHW: 37 87
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's signatur	e &	Rocall.			,		
	Registi	ar	JUL	1 2 2000 Meser	1	SALAS CA					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lenos С. Liston July 05 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Owings Mills 5001 Wards Chapel Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 29, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 F 216-28-4922 73 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland *how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "netural", or Itema 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at Baltimore Owings Mills Maryland 1 ☐ Yes 2X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21117 5001 Wards Chapel Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Be Completed by 3X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Book Keeper Building Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental if Item 27 is marked o 1 and 2 should be Richard Heineman Margaret 2 Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 Wards Chapel Road, Owings Mills, MD 21117 Burns Seva 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 Burial 2 □ Cremation 3 □ Removal from State ō Oak Lawn Cemetery July 11, 2005 Baltimore, Maryland permit. Page Department of importent: if any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors Inc 21. Signature of Funeral Service Licensee ph S ollier M00333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ROBI **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has autopsy performed 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. М 1 Yes 2 No investigation Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C 29a, Certifier 🏂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number Name and address of person who completed caus 31. Date filed (Month, Day, 32. Re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2005 **Physician** Dorothy June 17, Mebane 1:51 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Unit. | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) Units

New York 5. Social Security Number Unks. Sex 7. Age (In yrs. last-birthday) **Funeral** Days Hours 1 ☐ M 2 🗓 F 12/28/1925 Director 79 Yrs. Usual Residence of Decedent the Maryland 10a. State Unk 10b. County unk. 10c. City, Town or Location - unle-10d. Inside City Limits in than "neturel", or items 23a or 28a-f show the Medical Examinational be notified at WHY Yes 2 □ No Director Montgonery 1 Silver Spring 10e. Street and Number unk 10f. Zip Code Unit 10g. Citizen of What Country? UTI k. with 11106 Lutrell Lane 20902 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? UTILE 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. - Unit. 11. Marital Status o filed within 72 hours after call Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 □ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Unit (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Compl Elementary/Secondary (0-12) College (1-4or 5+) College Professor Education 17. Father's Name (First, Middle, Last) - 11 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 Is marked others. Be Nathaniel Gibbon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal McGinty / Daughter 1106 Luttrell Lane, Silver Spring, MD 20902 20b. Place of Disposition (Name of Unicometery, crematory or other place) 20c. Location - City or Town, State Beltsville, M. Washington, D.C. 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot ang. 08/08/05 Chesapeake Crem. 21. Signat Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Gastrointestinal Bleeding /Medical Due to (or as a consequence of) Examiner Peptic Ulcer disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rsician and e burial-transit The law requires that the death certificate be executed Cerebrovascular accident Due to (or as a consequence of) Box 68760 Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed I Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? res 20 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 2 ER/Outpatient 3XI DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 26765 June 18, 2005 person who completed cause of death (Item 23a Type, Print) & Hector K. Collison, M.D. 8401 Colesville Road #310, Silver Spring, MD 31. Date filed (Month, Day, Year) gistrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 U () 5 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** HARRY JULY 8, 11:30 A M DAVID MERMELSTEIN 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 130 SLADE AVENUE #611 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. APR. 15,1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 213-01-8481 92 Yrs. Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 130 SLADE AVENUE #611 21208 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE ģ Specify: 3 Nidowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 PROPRIETOR - PHARMACIST PHARMACY other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of eg **BERYL MERMELSTEIN** ROSE UNKNOWN ٥ 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a ILONA ROBINSON / DAUGHTER 2309 VELVET RIDGE DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) PARK 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL 07/10/2005 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocara Hours disease or condition resulting in death) /Medical Due to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be execused burial-fransil that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760 nding physician Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy lor Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐ Unknown 9 Unknown ط Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No NSION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 PNo funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 10 No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannyl of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident affer death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel or within 24 hours aff To the Funerel Di completely filled in Medical 29a. Certifier (s) and manner as stated. The continuation of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29d. Date signed (Month, Dey, Year) D0051896 05 8 UU MD 7 Muro \mathcal{O} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3635010 overt Pd LOWS MACINISO NUS 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 2005 Registrar

			For State	State of N	Maryland / Dep	artment of H			iene 9. N 2 0 0 5	22620
	۰	100	Registrar 1. Decedent's Name (First, Middle, i	.ast)		Timbale of I	Jeani	2. Date of Death	n	3. Time of Death
	Physici /Medio		Lelia	Po	00.			July	Day Year 11, 2005	12:35 A ^M
	Examin	-	4a. Facility Name (If not institution, s		•	4b. City, Town, or	Location of Death	•	4c. County of Dea	ath
	Funeral		Salisbury Nursi 5. Social Security Number 6		hab Center Age (In yrs. last birthday) If Under 1 Year	Salisbu	8 Date of Birth	Wicomie	
	Funeral Director		215-05-1953	1□M 2XF	88 Yrs.	Months Days	Hours Min.	Month, Day,		rthplace (State or Foreign ountry)
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryi -f sho Ilad a	to	M.D Wor	rester	00	pan P	nes			1 Tes 20 No
	ath with the Marylan s 23a or 28e-f show ust be nutited at	Director	10e. Street and Number	1 0	.0.1	10f. Zip Code	1/(_3	10	og. Citizen of What C	ountry?
	s 23a	rail	11423 Mank	lin Cree!	Rd.	21	811		USI	4
(0	ours after dea al', or Items Examiner ma	Funeral	 Marital Status Never Married 2 Married 	12. Was Deceder Armed Forces 1	\$?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
9036	ours a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 No	Specify:		Specify: U	hite.
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23s or 28e-f show fermatic event. It is Maxical Exactions in a state in the marked at	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occupa e kind of work done of DO NOT use retired	turing most of work	ing 1	6b. Kind of Busines:	s/Industry
212	d withi	ошо	Elementary/Secondary (0-12)	College (1-4o	(5+) AS	sistant	Manag	OP F	aichnes	Bouling
ES ud	al Hygi al Other	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Name	e (First, Middle, M	laiden Sumame)	3.56661779
FRANCES Maryland	should be nd Mental marked c	2	Wilson K	Spinson			Lydia	-	man.	
FR Mai	s 1 end 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street a	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
LIA ore,	of Hea		20a. Method of Disposition	J.J.	20b. Place of Disp	osition (Name of omatory, or other place		Date 2	20c. Location - City o	Town, State
P, LELIA Baltimore,	Page nent ent: If		1 ☑ Burial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe		Morelan	1 Nem. Par	ik 1-15	FOS [BALTIMO	RE MID
P, Ball	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Lic	ensee	1-	2. Name and Addres	ss of Facility	TIMOR	EMD 21.	234
POPP Ba			23a. Part1. Enter the disease, or o	mplications that caus	ed the death. Do not er	ter the mode of dvin	QUEALCI g. such as cardiac		1800 HHH24	Approximate
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final	ry one us on each	lma	00		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or a	is a neequence of):	Affect.	ency			910-
	Examiner	ē	Sequentially list conditions,	b. Duntakara	is a consequence of):	Des	e o e	-		gran-
	uted	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury that initiated events	Due to or a	is a consequence or,				- /	
oʻ	cate be executed physician and the burial-transit	Examin	resulting in death) Last	c. Due to (or a	is a consequence of):					
8760,	cate be ohysici the bu	dicai		d						
9	certific ding p	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				22d Data of de	liver
. Box	at the death certifi by the attending patached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐Live birth 4 ☐ Pregnant	2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	Day Year
P.0	at the d by th etache	Phys	9 Unknown	9□ Unknown				1		
	The law requires that the tite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause give	en in Part I.			o the cause of death?
cor	w requ	ompieted						24a. Was an		utopsy findings available
Re	sicien: The law certificate has t irector, page 2 s							autopsy perform	prior to death?	completion of cause of
/ital		BeC	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	
of	Ş isi	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpa				me 5 Resider 28d. Describe hov	nce 6 Other (Spe	ecify)
non	nding th. : After e funer	ation	1 □ Natural 5 □ Pending 2 □ Accident investigat	28a. Date of In (Month, L	Day Year) Injury	Work	rat k? Yes 2 □ No	Zou. Describe not	w injury occurred	
Division of Vital Records,	tel or Attending PI s after death. el Director: After the ed in by the funeral	ertification;	3 Suicide 6 Could not	be 28e. Place of I building.	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or R	ural Route Number,
	urs aft arel Di	O	00.00.00							
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 2 ertifying (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner:	st of my knowledge, dea of examination and/or in stated.	th occurred at the tim rivestigation, in my of	ie, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the Hospitel or within 24 hours after within 24 hours after To the Funerel Direction completely filled in b	Me	29b. Signature and title of certified	11		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	4		1/10	1		2	9349	1	/11/05	
	12		30. Name and address of person wh					1004		
	Sta	te	WILLIAM ROBINS 31. Date filed (Month, Day, Year)		CIVIC AVE.		RY, MD. 2	1804		
, F	Registr		wu 1 2	2005	e. H. 1.	barle				

			* COI	partment of Health and Menta	al Hygiene	
			1 0.5 0.111111	ertificate of Death	Reg. No. 005	22640
	Physici		1. Decedent's Name (First, Middle, Last)	Mo	te of Death onth Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	LY 7, 2005 4c. County of Dea	6:15 P [™]
			1515 POPLAR GROVE STREET	BALTIMORE CITY	NIA	-
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	y) If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. 4Mg	onth, Day, Year)	thplace (State or Foreign
	Director		Usual Residence of Decedent	re	6.11,1978 NI	aryland
	ryland show	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Ba-f s	ecto	Maryland NA Balt	imore		1 Yes 2 □ No
	with t	ā	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	death ms 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	d. Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,	es or No- 14. Race - Arne	
98	after or Ite	Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	etc.) Black, Whit	te, etc.
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exprined must be nuilited at	ed by	3 Wildowed 4 Divorced Year or Dates:	edent's Usual Occupation	Ь	lack
715	within 72 ene. than "ne	plet	(Specify only highest grade completed) (Size Elementary/Secondary (0-12) (Giv life.	re kind of work done during most of working DO NOT use retired)	16b. Kind of Business	Mindustry
	ed with	Completed	12	unemployed	N	4
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Experiest must be nutified at once.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Surname)) -V.
Ž	should nd Me mark mark imatic	1º		iling Address (Street and Number or Rural Route	Number, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is ar trau		Mrs. Carrie Parker 54	14 Bucknell Ro	1. Barto, Me	1.21206
Baltimore,	or oth		1 M Burial 2 Cremation 3 Removas from State 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	position (Name of ematory or other place)	20c. Location - City or	Town, State
Ë	rtmen rtmen rtant: njury		'4 Donation 5 Other (Specify) VOShell 21. Signature of Funeral Service Licensee	Mem. Gardens 110/20	005 Dunda	IK, Md.
Ba	permit. Departr Imports any inje		March L. Burn 2	oseph L. Ryss Fw	neral Home, 1	P.A. /-
			23a. Part1 Enter the disease, or complications that deused the death. Do not enshow, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respir	ratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	le Gunchet V	bunds	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
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	xecuted and I-transi	Examiner	that initiated events c.			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E	5 do 15 (6) 25 2 5011504201100 51).			
9	ifficate g physas the	edic	d.			
Вох	leath certific attending pl	an/N	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	: □Ectopic pregnancy	23d. Date of de	
	he dea the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐ Pregnant at time of death 5	Other (specify)	Month	Day Year
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of Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1	26. Place of Death (Checkent 3 DOA Other: 4 Nursing Home 5	-	SCENE
JO L	ding Phys h. After this funeral di	n: To		of 28c. Injury at 28d. De	escribe how injury occurred	city) DOLLAL
sior	andin eath. or: Aft	atio	1 Natural 5 Pending (Month, Jay Year) Injury 2 Accident investigation	M 1 Yes 2/2 No	which 84	عال ا
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. I lace f Injury · At home, farm, s building, etc. (Specify)	itreet, factory, office 28f. Loc Cit	cation (I treet and Number or Ri y or Town State)	ural Route Number,
_	spital			ath occurred at the time, date and place, and dur	e to the cause(I) and manner as	Stated. 2121.6
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Nedical Exeminer: On the basis of examination and/or in and manner stated.	investigation, in my opinion, death occurred at th	ne time, date and place, and due	to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	29c. License number OCME	29d. Date signed (Mont	
L	A		1 Horkewin	District Control	JULY 8, 20	
1)			30. Name and address of person who completed cause of death (Item 23a) (Type	^{e, Print)} 111 Penn Street I	Baltimore, Mary	land 21201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	ar	1111 1 2 2005 Henry	hoods		

1			. 101	State of Maryland / Depart			A A	
_			1 State Registrar	Cei	rtificate of Death		NZ U 05	22641
	Physici		1. Decedent's Name (First, Middle, Last)	11000		2. Date of Death Month JULY 3,	2005 Year	3. Time of Death 2:46 P M
	/Medic Examir		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Location of Death	J	4c. County of Death	2.40 F W
			HARBOR HOSPITAL		BALTIMORE CIT	Y	NA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 1 2 F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthpl	ace (State or Foreign
	Director		Usual Residence of Decedent	18 His.		Sept. 21,	1986 1114	ryland
	inyland ihow	_	10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits
	Be-f a	Director	Maryland N/A	Balti	more			1 Yes 2 □ No
	with ti	Dir	10e. Street and Number	PI	10f. Zip Code	10g.	Citizen of What Coun	ry?
	death ms 23	Funeral	11. Marital Status	. Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	ın Indian,
9	after or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【X No Specify:	Rican, etc.)	Black, White, e	tc.
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	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 Is markad other than "netural", or Items 23e or 28e-f ahow other traumatic event, If a Modical Examiner must be notified at		Ms. Charlene	Moore 28	37 Soelman	Rd. Ba	Ito Md	21225
Baltimore,	Pages 1 and the notest that the notest that the notest that the notest to note that the notest		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren	20b. Place of Dispo	esition (Name of matory or other place)	Date 20c.	Location - City or Tox	vn, State
tim			`4 ☐ Donation 5 ☐ Other (Specify)	NIT. Z	Jon	2005 L	an.sdov	ine, Md.
Ba	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	P. Russ Je	Name and Address of Facility Seph L. Kuss	Funeral	Home, P.	A;
			23a. Pagt1 Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	11101 212	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Multiple gunsho	L 1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (orlas a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
60,	cate be executed physician and the burial-transit		resoning in deathy cast	Due to (or as a consequence of):				
68760		edlcai	d.					
Вох	death certifi e attending od for use as	an/M	200. Was decedent pregnant	. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of deliver	y
.O. B	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)	·	Month (Day Year
<u>α</u>	that the ed by detacl		Part II. Other significant conditions contri	buting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
rds,	The law requires that the ate has been signed by th page 2 should be detache	ed by				1 ☐ Yes	2ANo 3□Proba	bly 4 ∐Unknown
Record	law requir as been s 2 should	ompleted				24a. Was an	24b. Were autop	sy findings available
		Com				autopsy performed 12 Yes 2 1	death?	pletion of cause of □ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	pital:	0.0	h Check onl one		
o		7: To	X 163 2 110	28a. Date of Injury 28b. Time of	28c. Injury at	me 5 Residence 28d. Describe how in	6 ☐Other (Specify)	
ion	Attending R death. ctor: After y the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Month, Day Year) Injury J. 1. 3 2005 2:10	Work? 1 □ Yes 2 No	Subject	t was shi	3T
Division	Hospitel or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, strabulding, etc. (Specify)	eet, factory, office	City or Town, Sta	and Number or Rural	
	ppitel	al Ce	29a. Certifier 1 Certifying Physic	porch of my knowledge death			nan Rd, Bellir	
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edica	(Check only one) (Check only one) Medical Examinat	ien: To the best of my krlowledge, death : On the basis of examination and/or inv and manner stated.	vestigation, in my opinion, death occur	red at the time, date a	no, and manner as sta and place, and due to	he cause(s)
	To the within To the COMP	Me	29b. Signature and title of certifier	1 0 4.	29c. License number OCI/E		Date signed (Month, D	
)	4			LeefMD		JT	JLY 4, 200	5
1	•		30. Name and address of person who come Tasha Z Green	pleted cause of death (Item 23a) (Type,	^{Print)} 111 Penn Street	Baltimore	e, Maryland	1 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Braistrar's Signature				
	Registr	-	JUL 1 2 200	5 Magna D. A.	me			

				ype or Print in Blac			-	•	le.	
			1 _ State	State of Maryland /	•	t of Health and N e <i>of Death</i>			E 22610	
		A	Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	3 OI Dealii	2. Date of Deat	9. N2 0 0	3. Time of Death	
	Physici		Insonh A Soit-	nonel			Month JULY	Day Y	905 7-54 AM	
	/Medic Examin		4a. Facility Name (If not institution give s	treet and number)	4b. City,	Town, or Location of Death	700	4c. County of	3.4	
	-Aumin	Ų,	GOOD SAMIARITAN	4 HOSPITAL	B	DALTIMIOR	Ê			
	. Funeral		5. Social Security Number 6. Sex	M 2 F 7. Age (In yrs. last bi	Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)	7
	Director		Usual Residence of Decedent	52	Yrs.		11-18	- 1952	MARYLHUE	
	/land		10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits	
	a-fst	ctor	MD BALT	IMORE	BALTI	MORE			1 □Yes 2 No	
	or 28	Director	10e. Street and Number	1	10f. Zip	Code	1	0g. Citizen of Wh	at Country?	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show iteal Examinar must be notified at	ral	9014 (nategi	gay Ct.	140 W - 5	41224	". Y N -	U.S.	#	
	Item	Funeral	11. Marital Status 1 Never Married, 2 Married	2, Was Decedent Ever in U.S. Anged Forces? 1 Z Yes 2 ☐ No		lent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	Rican, etc.)	Black,	American Indian, White, etc.	
5-0036	al', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify:	white.	
2-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a	a. Decedent's Usua (Give kind of wor	Il Occupation rk done during most of work se retired)	king	16b. Kind of Busi	ness/Industry	
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d 2	filed with Hygiene. other ther	e Co	17. Father's Name (First, Middle, Last)		Jule Sind	18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	Reproged	_
an	lid be lental kad c ic ava	To Be	Joseph A So	itznagel. S	R.	Doris	. Wh.	te.		
Maryland	2 should be and Mental Is markad o sumatic ave		19a. Informant's Name/Relationship		b. Mailing Address	(Street and Number or Ru		City or Town, St	ate, Zip Code)	П
	1 and 2 Health am 27 I		Daris Spitzna	gel-mother 40	14 Cha	teaugay	<u> (4., 154</u>	LTIMOR	15,MD 2123	4
ore	es of of of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	a comet	of Disposition (Nan ery, crematory or o	ne of ther place)	Date	20c. Location - Ci	ity or Town, State	
Baltimore,			*4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	taria	WXXX CLI	d Address of Facility A	4-05	PARCUI	THE MID	
Ba	permit. Departr Imports any inju		Kin bull	2 WATE	FUNA 1=	ELLIS PA	Charlet,	18800 H	234. Aptopio 00.	
13			23a. Part1. Enter the disease, or empliing shock, or heart failure. List only on	can no mat caus of the death.	not enter the mod	e of dying, such as cardiac	or respiratory arre	1	Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to (or as a consequence		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Examiner	<u>.</u>	Sequentially list conditions, b	Due to for as a consequence	S					
	nted nsit	Examiner	dany, leaving to in mediate cause. Enter Underlying Cause (Disease or injury	And to for an account	a cap					
ó	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		that initiated events cresulting in death) Last	Due to (or as a consequence	e of):		•			
3760	ate be ex nysician he burial	cal	d							
89 ×	leath certificate t attending physic I for use as the b	Physician/Medi	IF FEMALE:							
Вох	attend for us	lan/	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 Ectopic pr 5 Other (sp			23d. Date Monti		ı
P.O.	that the de led by the a detached i	nyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	5 🗆 Other (sp	ecily)	1,500-0-10			
	ires that signed b d be deta		Part II. Other significant conditions con		in the underlying c	ause given in Part I.	23e. Did tot	acco use contrib	oute to the cause of death?	
of Vital Records,	w require been sig should b	Completed by	ATRIAL FIBRI	-LATION			1 □ Y€	es 2□No 3	Probably 4 Munknown	t
ecc	e taw re has be ge 2 sho	ple					24a. Was a autops	v pri	ere autopsy findings available or to completion of cause of	а
<u>=</u>		Con					perform 1 ☐ Yes 2		ath? ☐Yes 2☐ No	
Σ Εξέ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Othor	th (Check only on			
of	Phys ir this sral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.		DA 4 Nursing H Bc. Injury at Work?	ome 5 Reside	ow injury occurred		
ion	nding F ath. r: After e funer	atlor	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division	Hospital or Attanding 44 hours after death. Funaral Diractor: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory	, office	28f. Location (St City or Town		or Rural Route Number,	
ā	ital o irs aft iral Di									
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 ★ Certifying Phys (Check only 2 ★ Medical Examination)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred and/or investigation	at the time, date and place, in my opinion, death occu	, and due to the ca rred at the time, d	ause(s) and manr ate and place, an	ner as stated. Id due to the cause(s)	
	To tha I within 2 To tha Complet	Me	29b. Signature and title of certifier		290	c. License number	2	9d. Date signed ((Month, Day, Year)	_
	. /		> FN000~L	or MD	(RES 000	y made group	5064 1	11 2005	
	FILL		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Print)	0. 15 0		- ^4	N •	
	4,		ROHINI NORONHA	32. Ray fair's Signature	KAUEN !	DLVD, IDAI	TIMOI	2 E / X/.	U 21239	
	Sta Regist		31. Date filed (Month, Day Year) 2 2	1005 Mileson L	& speed	e e				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Elizabeth 2005 jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIMONE UVIEW If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Director 19-26-2317 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director HYORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 6 432 Items 23a Completed by Funeral Nishwai USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 No 1 TYes Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: WKIFE 3 ₩Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN tome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ JOHN QKION 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tree ODGE. daughte 1432 Hwy , itaselli 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Crematory July 6 2005 Da 21. Signature of Funeral Service License 22. Name and Address Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mu ocar more be offe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 PNo
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending atter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a To the Funerel E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 OOKy 04363 odney 30. Name and address of person and completed cause of death (Item 23a) (Type, Print) Erdnea 3123 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			For State Registrar	Cortificate of Dooth							
	Physici		1. Decedent's Name (First, Middle, Last)	1120+				2. Date of Deat		3. Time of Seath 4	
	/Medic Examir Funeral	ner	4a. Facility Name (If not institution, give s FRANKIN Square 5. Social Security Number 6. Sex	Hospital Cente	ast birthday)	BOSCAM If Under 1 Year Months Days	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dea	th (C) thplace (State or Foreign ountry)	
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City	Yrs.			Feb. 11,	19/8	10d. Inside City Limits	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	MD Balt		Balti	MOKE 10f. Zip Code		1	0g. Citizen of What C	1 Yes 2 140	
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show amy injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral C		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 6 6 7 7 7 7 7 7 7 7 7 7 7		2/2 s Decedent of His es, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
ACA 21215-0036	d within 72 hou giene. er than "natura er than "natura	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deceder (Give kir life. DC	nt's Usual Occupa ad of work done do NOT use retired)	uring most of work	ing .	16b. Kind of Business	Home	
l, Cl	2 should be filed and Mental Hygi Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) JOHN Piel	cy			18. Mother's Name	e (First, Middle, I			
\mathbb{S} $ eg$ $ eg$ $ eg$ $ eg$ $ eg$ $ eg$ altimore, Maryland	and 2 sho ealth and I n 27 Is me		Diave Halle	- Daughter	524	Nollm	everR	d, Bal	City or Town, State,	2/220	
stel	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R • 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	yvicu	ion (Name of tory or other place) Cremi	vay 7/1:	2/05 (20c. Location - City or Baltimon		
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	ar	22,1	lame and Address	s of Ficility 1-ASht	Spring	ueral Hor		
	Physician	al Examiner	23a. Pant1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death ne cause on each line.	Do not enter	the mode of dying	g, such as cardiac d	or fespiratory arr	est,	Approximate Interval Between Onset and Death	
8760,	Medical Examiner bhysician and sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
P.O. Box 687	The law requires that the death certilicate the has been signed by the attending physinge 2 should be detached for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	.3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□E	ctopic pregnancy Other (specify)			23d. Date of de Month	Divery Day Year	
ds, P.	rires that t signed by d be detai	edical Certification; To Be Completed by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the und	erlying cause give	in in Part I.		pacco use contribute t es 2⊠No 3⊟P	o the cause of death?	
al Recor	(G) CT		Infarction, cerebrovascular accident Acute renal failure 24a. Was an autopsy performed 10 Yes 28					ned? death? 2⊠No 1⊡Ye	24b. Were autopsy findings available prior to completion of cause of death? 10		
Division of Vital Records,	this a		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	lospital: La Inpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at	me 5 Reside	ence 6 Other (Spa	ecify)	
Divis	al or Attending F s atter death. al Director: After ed in by the funer.		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stree	t, factory, office		28f. Location (Si City or Town	reet and Number or R n, State)	dural Route Number,	
	he Hospil in 24 hour he Funera pletely fille		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		W	29b. Signature and title of certifier	But	inn	29c. License	381		9d. Date signed (Mon	th, Day, Year)	
	67		30 Name and address of person who co	-Sakili MD	9000 F	int) ranklin	Square I	PRIVE I	Paltimore, A	1)21237	
:	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 2 2005	30 Alegistrar's Signal	does.	W					

			State of Maryland / Dep		ental Hygie	ene	
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Tuncale of Dealif	Reg 2. Date of Death	. No. 2005	22645
	Physici	an	Ethel C. Secrist			2005 Year	6:25 P M
	/Media		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July J,	4c. County of Death	0.23 F W
	Examir	ier	Bradford Oaks Nursing Home	Clinton		Prince Ge	orgate
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		
	Director		579 09 1454 1 M XXF 85 Yrs.	Months Days Hours Min.	(Month, Day, Y July 29.	(ear) Coul 1919 Was	place (State or Foreign ntry) hington DC
	D		Usual Residence of Decedent		July 27,		
	arylar show	_	10a. State 10b. County 10c. City, Town or L			1	10d. Inside City Limits
	8a-f	ecto	Maryland Prince George's Brandy				1 □ Yes 2 No
	with ti	Ö	10e. Street and Number 12910 Brandywine Road	10f. Zip Code 20613		n Citizen of What Coul United Sta	•
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinat must be notified at	Completed by Funeral Director					
	lter dr	in in	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 ☑ 1 ☐ Yes	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	14. Race - Americ Black, White,	
936	urs af	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Tho If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ XNX Specify:		Specify: Wh	ite
21215-0036	2 hor	ted	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	ib. Kind of Business/In	dustry
215	e. en "r	ple	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workii DO NOT use retired)	ng		
	ed wi	S		Government Printer			Bindery Wo
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
yla	Meni Meni arke	2	Thomas Edward Callahan		Rose Da		
Maryland	2 sh end la m raum			ing Address (Street and Number or Rura 10 Brandywine Road,			0613
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or ftems 23a or 28a-4 show any injury or other traumatic event, the Madical Examinat must be notified at ance.				_		
Baltimore,	in the		1) Laborar 2 Cremation 3 Chemoval Irom State	osition (Name of matory or other place) July 11 ^D ,		c. Location - City or To	
ij	it. Pa rtmer rtant njury			Hill Cemetery		uitland, M	
Ba	Department of the partment of			2. Name and Address of Facility Lee			
				Alexandira Ferry Ro			735 Approximate
			23a. Part : Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	_	4 1		Interval Between Onset and Death
	Physician / Medical		resulting in death)	CANNOV Markon	allas	~	gener
	Examiner		Due to (or as a consequence of):				0
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V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
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	e dea the at	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.0	d by tetach	Physician/Med	9 Unknown		Too Billio		
S,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.		cco use contribute to the	pably 4 Unknown
Records,	w requir been si should	Completed				2/200 301100	
ec	e 2 s	nple			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
E F				·	performe 1 Yes 25	d? death? No 1 ☐ Yes	2 No
Vital	Attending Physician; The law rideath. cleath. ector: After this certificate has toy the funeral director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
ō	Phys this ral dii	- T	1 ☐ Yes 2 ☑ No ☐ Inspiral 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time (Int 3 DOA Nursing Hon		e 6 Other (Specification)	y)
LO LO	ding Phy h. After thi funeral (tion	1 (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	8d. Describe how	injury occurred	
Division	Attendil death. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, si		8f. Location (Stree	et and Number or Rura	N Route Number
Σ	after Dire	Certification;	4 Homicide determined building, etc. (Specify)	accor, ractory, onlos	City or Town, S	State)	ir rioble ryumber,
	To the Hoapital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ai C	29a. Certifier XXCertifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the caus	se(s) and manner as s	tated.
	e Ho 124 h 19 Fui letely	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To the withir To the To the To the To the Comp	M	29b. Signature and title of certifier	29c License number	29d.	. Date signed (Month,	Day, Year)
				019431		7/6/00	
	JO.		30. Name and address erson o completed cause of death (Item 23a) (Type	D19931 103 77- Washingt	W mo	71541	,
	Sta	ite	Frank Ryan (17) (17) (18) 31. Date filed (Month, Day, Year) (18) 22. Registrar's Signature	the	** <i>(**)</i>	0177	
	Registi	rar	JUL 1 2 2005 Men 15 19	- C			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** July 7, Joan Leslie Serio /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/1/1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2878 63 214-40-8820 Director Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Items 23a or U.S.A. 21236 3 Mopec Circle Apt B Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 9 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 Divorced natural', Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Nichols Elizabeth Ann Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Zack /Daughter 3 Mopec Circle Apt B. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore/Wash. Crem. 7/14/05 Laurel, Maryland ☐ Donation 5 ☐ Other (Specify) 21. Squature of F eral service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. alm 6415 Belair Road Baltimore, Maryland 21206 28a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer ung /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 1 ☐ Yes or Attending Phyalcian: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification; To To the Funeral Director: After thi completely filled in by the funeral

State Registrar 27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 Homicide

5 Pending investigation

6 Could not be

and title of certifier

1aria 31. Date filed (Month, Day, Year)

determined

JUL 1 2 2005

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral D To the Hospital

Medical

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

43725

28d. Describe how injury occurred

2300 Dulaney Valley RD. Timonium, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28a. Date of Injury (Month, Day Year)

and manner stated.

Mah mood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / D	epartment of Health and N	•	9	
		•	4 101	Certificate of Death		N2005	2261.7
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	iysici: Medic		Johnella Gwendolyn Toombs		June 29,	Day Year 2005	4:00 P M
Ex	kamin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
F			Southern Maryland Kospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Clinton Iday If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Prince Ge	orge's
	neral ector		578 30 0578 1½M 2□F 78 Y	Months Dave Hours Min	8. Date of Birth (Month, Day, Y	rear) Cou	place (State or Foreign untry) Virginia
pu »	200		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		1148 50,	1720 WEST	
Aaryla Fshor	a par	ō	3.6				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the h	netifi	rect	Maryland Prince George's Clinto	10f. Zip Code	100	. Citizen of What Cou	XX
death with the Maryland	athe	Funeral Director	8600 Mike Shapiro Drive #814	20735		United Sta	•
r dea	NU JA	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer Black, White	ican Indian,
s afte	OH CHI	by Fu	1 □ Never Married XXX Married 1 □ Yes 2X□ No 1 □ Yes 2X□ No	1 ☐ Yes XX No Specify:	, , , , , ,	Specify: Afr	
Z I Z I D-UUSO d within 72 hours af giene. ar than "naturai", or	CALE	led h	15. Decedent's Education 16a.	Decedent's Usual Occupation	16	Ame Bb. Kind of Business/I	rican
7	Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	Give kind of work done during most of work life. DO NOT use retired)	ing		
ed will	The state of	Con	12	Statistical Typist		Federal Go	vernment
yiand ould be file Mental Hy arked oth	evan	Be	17. Father's Name (First, Middle, Last) Carl Redman		e (First, Middle, Ma	/	
thould Me	matic	2		Mailing Address (Street and Number or Rui	Duvall F		in Code)
Mar nd 2 sh alth and 27 is m	r trau		T 0 m 1 (1)	600Mike Shapiro Driv			
ore, of Head	r otha		20a. Method of Disposition 20b. Place of	Disposition (Name of	Date 20	c. Location - City or 1	Town, State
Page ment	ury o		'4 Donation 5 Other (Specify)	Hill Cemetery July 6	, 2005 S	Suitland, 1	Maryland
baitimore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene.	ny Inj		21. Signature of Funetal Service Ligenses	22. Name and Address of Facility Lee	Funeral	Home, Inc.	6633 O1d
<u> </u>	a 0		23 m1. Enter the disease, or complications that caused the death. Do not	Alexandira Ferry R			35 Approximate
D1			shock, or heart failure. List only one cause on each line.		or respiratory arres	,	Interval Between Onset and Death
Physic /Med			disease or condition resulting in death) Due to (or as a consequence of the control of the cont	Lmonary Emboli			days
Exam	iner		Corvival Spir	ne Stenosis/Quadrill	eria		days
J B	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events).			days
be executed ician and	I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of the consequence of t	f)·			
fou, te be ex ysician a	he burial-transit	calE	d.	,			
Certificate	as the						
ath cer	be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deli	•
the death	hed fo	/sici	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{Line bitth} \) 2 \(\text{Petal death} \) 9 \(\text{Unknown} \) 9 \(\text{Unknown} \) 9 \(\text{Unknown} \)	5 Other (specify)		Month	Day Year
that the bed by	detac		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ords, Prequires that	ed bl	d by	Kidney failure, dialysis, hyperte		1 ☐ Yes		bably 4 Unknown
	should	ojete		•	24a. Was an	24b. Were au	topsy findings available
The It	раде	Completed			autopsy performe 1 ☐ Yes 27	d? death?	ompletion of cause of 2 No
VITAL iclan: T	irector, page 2 s	Be C	25. Was case referred to medical examiner?		h (Check only one)	Δ	
OT VITA Physician: this certific	the funeral director,	2	1 ☐ Yes X2☐ No Hospital: 1 ☐ patient 2 ☐ ER/Out			ce 6 Other (Spec	ufy)
	funer	tion		me of 28c. Injury at jury Work? M 1 Yes 2 No	28d. Describe how	rinjury occurred	
VISI Attan r deal	by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far			et and Number or Ru	ral Route Number,
UIVI tal or At rs after c	ed in l	Certification:	4 ☐ Homicide Getermined building, etc. (Specify)		City or Town,	State)	
Hospi 4 hour	ely fill	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated.
LIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After	completely filled in by	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
F × F	8		Mary May MO	D006165		Till 7A	2005
1	լ		30. Name and address of person who completed cause of death (Item 23a) (100	
)		Atul Katyal, M.D., 9131 Piscatawa		Clinton. M	4D20735	
D.	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		_,		
DUMU 17.5	egistr	all 001	JUL 1 2 2005 Reserve 15 1	men			

State of Maryland / Department of Health and Mental	Hygiene
Contilionts of Dooth	2.6

		Certificate of Death	Reg. Ne	005 22648
	Physicia	Decedent's Name (First, Middle, Last)	2. Dete of Death Month Day	3. Time of Death
	/Medica	Charles Frederick Transou, Sr		5 2005 9.15 AM
	Examine		cation of Death 4c. (County of Death
		Genesis Multi Medical Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Balto 9. Birthplace (State or Foreign
ı	Funeral Director	246-42-1032 TALE M 2 F 74 Yrs. Months Days Hours Min. Usuel Residence of Decedent	8. Date of Birth (Month, Day, Year) 6-25-193	Country)
	/land	10a. Stete 10b. County 10c. City, Town or Location		10d. fnside City Limits
	Mary	Md N/A Balto		1)X Yes 2 □ No
	4 28 th	Md N/A Balto 10e. Street end Number 10f. Zip Code	10g. Citiz	en of What Country?
	ath w			S A
	e er er	1UZI ST DURSTARS KOACI 1. Marital Status 1. Never Married 2 Married 1. Never Married 3 Married	Prican, etc.)	Race - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0020	es.	3 ☐ Widowed 4 ☐XDivorced If Yes, Give Year or Dates:		Specify: Black
S C	72 ho	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng	nd of Business/Industry
127	I be filed within ntal Hyglene. ed other than event, the Me	Elementery/Secondary (0-12) College (1-4or 5+)	St	tate of Maryland
2	P P P	12th 2 years Bus Driver 17. Father's Neme (First, Middle, Last) 18. Mother's Name	(First, Middle, Maiden S	Surname)
a	ould be f Mental I erked of atic eve	John Henry Transou Marecia	Tucker	
<u>a</u>	중 문 트	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	I Route Number, City or	Town, State, Zip Code)
Σ	5 5 5 5	Charles F. Transou, Jr - Son 2025 Stonewick Avenue	Kannapoli	Is. N. C. 28081
0	- I 5 5	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Loc	cation - City or Town, State
Ě	nit. Pages bartment of l cortant: If Its Injury or o	4 □ Donation 5 □ Other (Specify) King Memorial Park 7		dallstown, Md
g D	permit. Pages Department of Important: If It any Injury or once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ma 4300 Wabash Av	rch F/H We enue Balto,	
		23a Part Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac o	r respiratory arrest.	Approximate
No.	Physician	23a. Fert1. Enter me disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition resulting in death) a. CELEBROUPS WIAN AC	CIDEN	DAYS
	Examiner	Due to (or as a consequence of):		
	D # .	MYELODYSPLASIA		i
	ficate be executed physician and is the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		
98760	slclar buri	Cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):		
9	daath certificate be executed e attanding physician and ed for usa as the burial-transit	Sequentially list conditions, if env, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. MYELODYSPLASIA Due to (or as a consequence of): C. Due to (or as a consequence of):		
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	the at	Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco u	use contribute to the cause of death?
0.	The law requiras that tha daath ce ata has been signed by the attandi paga 2 should be datached for uss		1 Yes 2	□ No 3 □ Probably 4 □ Unknown
or Vital Records,	uiras n sign	25. Was case referred to medical examiner?	24a. Was an autops	sy 24b. Were autopsy findings
င္ပ	w require s been sl		performed?	available prior to completion of cause of death?
Ÿ	he la tahas aga 2		1□ Yes £k	1 ☐ Yes 2 ☐ No
	rtifica ctor, p	25. Was case referred to medical 26. Place of Death		
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ב	Ing P	27. Manner of Death 28a. Date of fnjury 28b. Time of Injury at Work? 28c. fnjury at Work? 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how injury	occurred
JIVISION	or Attending Physicien: The law lifer death. Nector: After this certificata has in by the funeral director, paga 2	2 Accident investigation 3 Suicide 6 Could not be could	28f. Location (Street and	d Number or Rural Route Number,
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	To the Hospital Within 24 hours a To the Funeral C completely filled	1 Yes 2 Mo		
	within 2 Within 2 To the F complet	end manner steted. 29b. Signature and title of certifier 29c. License number	29d. Date	e signed (Month, Day, Year)
	₽¥₽8			
Í	(d/	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	330	710-1,2005
-	YT V	SO ALCUNHALA GUPTA 9650 SANTIAGO ROAD	SUITE 110	COLUMBIA
	Stat	31. Date filed (Month, Day, Year) 32. Registrer's Signeture		9093
	Registra	THE IS COULD DEFEND TO WARRENT TO		

			roi	epartment of Health and N	lental Hygie	ne	0 2 0 0
			1 - State Registramend ITEM #26 PER PHY C845 7	ெர் ர்த்து of Death		N2005	22649
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Leonard Franklin Viers		July 6,	2005	7:55 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
_			1501 Shawan Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Cockeysville	8. Date of Birth	Baltimo	
	Funeral Director		214-26-5373 ¹ ⊠™ ² □ F 86 Yi	Months Days Hours Min.	(Month, Day, Ye		place (State or Foreign intry) t Virginia
	D		Usual Residence of Decedent		, bept 3,		
	arylar show	_	10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	8a-f	Director		keysville			1 ☐ Yes 2 No
	with the		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	eath	eral	1501 Shawan Road 11. Marital Status 12. Was Decedent Ever in U.S.	21030 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - Ameri	ican Indian
0	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Exercinet must be rediffed at	Funeral	Armed Forces? 1 □ Never Married 2 ▼ Married I ▼ Yes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
ğ	al', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: Wh	ite
21215-003	72 hc	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work	king 16t	b. Kind of Business/Ir	ndustry
2	Atthin ne.	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)			
	filed within 72 h Hygiene. other then "netu ent, It e Madica	ပ္ပ	8 n/a 17. Father's Name (First, Middle, Last)	Machinist	ne (First, Middle, Mai	Harry T.	Campbell
au	d be fandal had of	o Be	Pleasant Viers	Fanny	Ethe		lon
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-1 show itam 27 is marked other than "natural", or itams traumatic event, it a Macalcal Exercities must be notified at	ြ		Mailing Address (Street and Number or Ru			
	5 # 7 # Z		Eugene B. Viers/Son 15	01 Shawan Road, Coc	kevsville	MD 2103	30
altimore,	es 1 and 3 of Health fitam 27 r othar tr		20a. Method of Disposition 20b. Place of I	isposition (Name of crematory or other place)		c. Location - City or T	
Ē			1 A Burial 2 Cremation 3 Hemoval from State	Rock Cemetery 7/9	/05 I	Butler, Ma	ryland
a	permit. Pag Department Important: I any injury o		21. S'antiture o Funeral le viul Licente :	22. Name and Address of Facility Lemmon Funeral Hom	e of Dula	new Valley	z Inc
<u> </u>	205 20		Bryan W. Clary	10 W. Padonia Road	. Timoniu	m. MD 210)93
п			23a. Part1. Inter the disease, or complications that caused the death. Do no shock or heart ailure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest	•	Approximate Interval Between Onset and Death
	Pnysician		Immediate ause inal disease or c.h. n resulting in death)	CANCEN		-	6MONTHS
	/Medical Examiner		Due to (or as a consequence of	:			
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	:			
	uted d ansit	Examiner	cause. Enter Underlying Lates Citisdes of thus that initiated events C.				
o,	a exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of				
8760,	ficate be executed physician and s the burial-transit	dlcal	d				
9	ertifica ling pl	Med	IF FEMALE:				100
Box	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	3 Dectopic pregnancy		23d. Date of delive	very Day Year
o.	he de rhe d	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
Δ.	The law requires that the death cerdifi ste has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Dther significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
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Vital	ysiclan: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)		
<u>></u>	dii d	10	1 ☐ Yes 2 ♠No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out		ome 5 sidend	e 6 Other (Speci	ify)
ñ	ing P	on:	Takutai S_T bilding	ury Work?	28d. Describe how	injury occurred	
Division of	ttand death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far	M 1 Yes 2 No	28f Location (Street	et and Number or Rui	ral Route Number
<u>≤</u> .	lor A after Dirac	Certification:	4 Homicide determined building, etc. (Specify)	i, street, factory, office	City or Town, S		ar riouid rearriodr,
_	To the Mospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	, and due to the caus	se(s) and manner as	stated.
	na Ho n 24 h ne Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.				
	To tha Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	M	29b. Signature and title of certifier.	29c. License number		. Date signed (Month	
)			ATTENO,NO	000.2553	3	71810	15
	141		30. Name and address of person who com, leted cause of death (Item 23a) (1	ype, Print)	1	7	MA SISI
	`		Yeter Stamas M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	8520 Dellona	Ave.	10WSON 1	21207
	Sta Regist		JUL 1 2 2005	\$320_ Bellona			

		•	, ror	Department of Health and Mei Certificate of Death	ntal Hygiene	000
	Physici	an	1. Decedent's Name (First, Middle, Last) Demond Latroy		Date of Death Month Day 1017 3, 20	3. Time of Death 10:49 p. ^M
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death
			Malcolm Grow	Camp Springs	Pr	cince George's
	Funeral Director		5. Social Security Number 251-55-8714 Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Year) Sept. 17,1	9. Birthplace (State or Foreign Country) 1983 South Carolina
	ryland thow		10a. State 10b. County 10c. City, Town			10d. Inside City Limits
	he Ma	ecto	Maryland Prince George's	College Park	10- 6	1 Yes 2 No
	3e or 3	I Dir	9308 Cherry Hill Road Apt. 804	10f. Zip Code 2074:0	Tog. Cit	U.S.A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or itams 23e or 28e-f show amy injury or other traumatic event, the Modical Exp., instruct by notified at ances.	by Funeral Director	11. Marital Status 1 \(\begin{align*} \text{Mar Never Married} & 2 \begin{align*} \text{Mar ned Forces?} & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces? & 1 \(\begin{align*} \begin{align*} \begin{align*} \text{Mar Decedent Ever in U.S.} & Armed Forces & 1 \(\bext{Mar Decedent Ever in U.S.} & Armed Forces & 1 \\ Mar Dec	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	ithin 72 ho ne. han "natur e Madical I	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		ind of Business/Industry
	filed w Hygie wher t		17. Father's Name (First, Middle, Last)	Senior Airman Active 18. Mother's Name (F		S. Air Force
Maryland	Mental Mental rrked o	To Be	Henry Bradley		Wells	
Mary	12 should h and Men 7 is marke reumatic			Mailing Address (Street and Number or Rural R		
	s 1 and f Health Item 27 other to	78		1535 Command Dr. B-208 f Disposition (Name of ry, crematory or other place) July 1		ocation - City or Town, State
imo	Pages nent or ant: if		1 X X Defiai 2 Cremation 3 Chemoval nom State	ord Cemetery 2005		iter, SC
Baltimore,	permit. Departrimportuany inji		21. Signature of Funeral Service Licenses Storling MO1431		Funeral	Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Muthole Injury.	i'es		
	Examiner		Sequentially list conditions, b			
	nsit	Examiner	Tany, leading to immediate Gue to (or as a consequence cause. Enter Underlying Cause (Disease or injury	of):		
8760,<	cate be executed obysician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence	of):		
687	ficate by physical the part of	edlca	d			
.O. Box	the death certificate be executed y the attending physician and ched for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
C	requires that the de sen signed by the s tould be detached t	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		use contribute to the cause of death?
Vital Records,	Physician: The law require t this certificate has been si rral director, page 2 should b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ita	stan: artifica ictor, p	Bec	25. Was case referred to medical examiner?	26. Place of Death (C		
of V	Physician: this certific ral director,	2	1 Yes 2 No Hospital: 1 ☐ Inpatient 2 AER/Ou		5 Residence	6 Other (Specify)
lon	nding Phy th.: :: After thi e funeral	atlon		Time of Injury at 28c. Injury at 28c Work? 1 ☐ Yes 2 ☐ Yes	opraycle e	thees striking vehicle
Division	or Atternation after designation Director	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Tace of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office 281	City or Town, State	nd Number or Rural Route Number, e) Dower House Road,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerei Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and place, and	due to the cause(s	and manner as stated.
	To th within To th	Me	29b. Signature and title of certifier	29c. License number OCME	29d. Da	ate signed (Month, Day, Year)
			I Jana Beel no		•	
	10 41		30. Name and address of person who completed cause of death (Item 23a) Tasha 2 Green ben M.D.		Baltimore	e, Maryland 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year) Registrar's Signature	berki		

			1 - For State Registrar	State of Man		artment of H tificate of L			iene 	22651
	Physicia	an	1. Decedent's Name (First, Middle, Last) Dorothy Eliz	abeth Wa	do			2. Date of Death Month July 2,	h	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give str		de	4b. City, Town, or	Location of Death		4c. County of Deat	5:20 A.M.
			12810 LaPlata Ro			Waldorf			Charles	
	Funeral Director		5. Social Security Number 6. Sex 1 1 N	7. Age (II	n yrs. last birthday) 8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 26,	Year) Co	hplace (State or Foreign untry) y land
	and we		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	Maryland Charles		Waldo	rf				1 ☐ Yes 2XXVo
	with the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	
	ns 236	Funerai	12810 LaPlata Ro	. Was Decedent Eve	er in U.S. 13. \	206 Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	United Sta	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23e or 28e-f ehow matic event, it a Medical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates:	į.	f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify:	e, etc. African
Maryland 21215-0036	72 hour		15. Decedent's Educa (Specify only highest grade of	ition	16a, Dece	lent's Usual Occupa	ation	ring	Ame 16b. Kind of Business/	rican
121	be filed within 72 tal Hygiene. d other than "natewent, the Midle	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	omemaker)	9	Own Home	
מ טנ	e filed Il Hygie other	Be Co	17. Father's Name (First, Middle, Last)		11	Omemaker	18. Mother's Nam	e (First, Middle, N		
ylaı	should be f and Mental P s marked of umatic eve	ToE	Adrian P. Johnson	D: 4	101 11 11		Ida Woo			
Z	permit. Pages 1 and 2 should by Oppartment of Health and Mental Important: If Item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type Yvonne Wade (Daught						City or Town, State, 2 Maryland	. ,
altimore,	of Hes		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Rer	noval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	July 7,	^{Date} 2005	20c. Location - City or	Town, State
Ĕ	it. Pag intment intant: I injury c		'4 □Donation 5 □ Other (Specify) 21. Sign, ture f Funeral Service J ensee		St. Marv	's Church	Cemeter	v]	Bryantown,	
Ba	Deperment of the population of	, ,	Mayis L. Front	moo25	7 A	lexandira	Ferry R	Funeral d. Clinte	Home,Inc 6	6633 01d 735
	3		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pneum						Few Days
h	Examiner		Sequentially list conditions, b.	Due to (01 as a c	onsequence ory.					
	ted nslt	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events c.	Due to (or as a c	onsequence of):					
o,	a execu an and irial-tra		that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):					
68760,	iicate be executed physician and s the burial-transit	dical	d.							
Box (attending p for use as	ın/Me	230. Was decedent pregnant	c. If yes, outcome of p		Ectopic pregnancy			23d. Date of del	ivery
о. В	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ဩ No 9 ☐ Unknown	4□Pregnant at tirr 9□Unknown		Other (specify)			Month	Day Year
۵.	res that tigned by	y Ph	Part II. Other significant conditions contr	ibuting to death but n	not resulting in the u	nderlying cause give	an in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	w require been sig should b		Anmemia					1 ☐ Ye	s 2 No 3 Pr	
Rec	The law cate has b page 2 s	Completed	Failure to Thrive					24a. Was ar autops perform	ned? death?	topsy findings available completion of cause of
Vita		Be Co	Goiter 25. Was case referred to medical examiner?				26. Place of Deat	1 ☐ Yes 2 th_(Check only on	TA.	2 □ No
	g :s Z	P	1 ☐ Yes 2 X No Ho.	spital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 🗆 Nuising no	ome 5 X Reside	nce 6 Other (Spe	city)
on	nding lath. r: After se funer	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	Work	(? Yes 2 □ No	200. 2000.100 110	Williamy Coouried	
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
ш	hours a		29a. Certifier XXCertifying Physic	cian: To the best of n	ny knowledge, death	occurred at the time	ne, date and place,	and due to the ca	luse(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) 2 Medicel Examine	er: On the basis of ex and manner stated	camination and/or in	vestigation, in my or	oinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
)	To To Cor		29b. Signature and title of certifier			29c. License	D44436	2	TIME 0 7	Day, Year)
	1		30. Name and address of person who com			Print)				
	Sta	to.	Ashviwkumar J. Pa	ite1, MD,		ellow Cou	rt #102,	Waldrof	, MD 20602	
	Registr		JUL 1 2 2005		Is for	We I				

amend item#/,8, perfff, G845, //21/05 11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N2 0 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JOSEPH ELMER WEISHEIT JULY 2005 3:30a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner 413 BRIGHTWOOD CLUB DRIVE LUTHERVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 18/1919. Birthplace (State or Foreign (Month, Day, Year) | 19/1919. Birthplace (State or Foreign (Month, Day, Year) | 19/1919. Birthplace (State or Foreign (Month, Day, Year) | 19/1919. Birthplace (State or Foreign (Month, Day, Year) | 19/1919. Birthplace (State or Foreign (Month, Day, Year) | 19/1919. Birthplace (State or Foreign (Month, Day, Year) | 19/1919. Birthplace (State or Foreign (Month) | 19/1919. Birthplace (Month) 5. Social Security Number 214-38-4728 7. Age (In yrs. last birthday) **Funeral** Months Days 1(XM 2□ F 86 Director 85s. Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE LUTHERVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 Items 23a 413 BRIGHTWOOD 21093 CLUB DRIVE Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? ▼☐Yes 2 ☐ No ff Yes, Give Year or Dates: ₩₩ I I Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 27 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY ATTORNEY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental H Pages 1 and 2 should be 1 JOSEPH ELMER WEISHEIT INGREET PATTISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LUTHERVILLE, MDf of Heelth 413 BRIGHTWOOD CLUB DRIVE JACQUELIN WEISHEIT wife 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Importent: If eny Injury or once. DRUID RIDGE CEM. JULY 11, 2005 PIKESVILLE, MD 22. Name and Address of Facility HENRY W. JENKINS & 21. Signature of Funera Sep SONS CO. 16924 YORK ROAD MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final Monar Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Leer Vein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physiclen and use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed Chronic 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was an autopsy performed?
Yes 241 No certificate 1 🗌 Yes Hospitel or Attending Physiclen: director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 2/2 1 🗌 Yes Certification: To 3 DOA this 28d. De cribe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funerel DI completely filled in To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 2 ed cause of ath (Item 23a) (Type, Print) 30. Name and address of person who complet 020 homas 1075 31. Date filed (Month, Day, Year) strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 112/05 IT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician July WHITEMAN 9, 2005 MARCIA 12:45pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 8. Date of Birth (Month, Day, Year) NOV. 21, 1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days 1 □ M 2 1 F 84 219-01-0294 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Madical Examiner roust be notified at 1 ☐ Yes 2 ☑ No MD BALTIMORE Director OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 11112 VALLEY HEIGHTS DRIVE 21117 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry filed within 7 Hygiene. 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE OFFICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNOBTAINABLE) GOLDBERG ALBERT BESSIE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat <u>once.</u> 11112 VALLEY HEIGHTS DRIVE - OWINGS MILLS, MD 21117 ALFRED WHITEMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH JACOB CEMETERY 07/10/2005 FINKSBURG, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Funeral Servic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kenal Immediate Cause (Final Physician Failur disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. East of control cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2☐No 3☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2. No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier troade Do. atherene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dimenione Mo 20 thevi 21093 Ca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State hour & Spark Registrar

		•	oe or Print in B tate of Maryland	d / Depa		lealth and M	lental Hyg	_	
Dhysinis		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Yea	3. Time of Death
Physicia /Medic	al	LEON	н.	WA			July	3 200	
Examin	er	4a. Facility Name (If not institution, give stre	et and number)			r Location of Death	,	4c. County of D	N/A
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign
Director		087-12-1142 1X M	^{2□ F} 81	Yrs.			JUL.28,	1923	LATVIA
ryland		10a. State 10b. County	10c. City	, Town or Lo		-			10d. Inside City Limits
he Ma 8a-f s	ecto	MD N/A		BALT	IMORE			0g. Citizen of What	1 N Yes 2 No
3a or 3	Funeral Director	10e. Street and Number 3031 FALLSTAFF ROA	D #301		10f. Zip Code	21209	'	og. Citizeri di vvilat	USA
death	nera		Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian, /hite, etc.
ges 1 and 2 should be filled within 72 hours after death with the Maryland it of Health and Mental Hygiene. And Health and Mental Hygiene. Or other traumatic event, the Macical Examinar must be notified at	by Fu	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:		1□Yes 21X No	Specify:		Specify:	WHITE
72 hou		15. Decedent's Educat (Specify only highest grade of	on ompleted)	(Give		during most of work	king	16b. Kind of Busine	ss/Industry
within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			WHOLESALE	
filed Hygie othar	Be Co	17. Father's Name (First, Middle, Last)		ONITE	IX	18. Mother's Nam			
ould be Menta arkad atic ev	To B	DAVID		WAIS		MARY		KRAMER	
d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, FRANCES WAIS / WII	'			FF ROAD #			
s 1 and f Health itam 27 othar tr		20a. Method of Disposition	20b. Pi	ace of Dispo	sition (Name of matory or other pla			20c. Location - City	
Pages nent of h ant: If its ury or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)				PARK 07/1	0/2005	RANDALI	STOWN, MD
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any njury or other traumatic event, ILE M. ODCE.		21. Sign has of Juneral Service License	nion			ess of Facility SO TERSTOWN			S., INC. E, MD 21208
Fnysician /Medical		Z3a. Part 1. Enter the disease, or complica shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death)	ions that caused the death cause on each line. B-Cell lum Due to (or as a consequ	phomo		ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
rate be executed thysician and the burial-transit	dicai Examiner	Sequentially list conditions, daily, leaving to the edition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence)	vence of):	heart dis	seuse			20 yeas
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	□Ectopic pregnand □ Other (specify) _	ey .		23d. Date of Month	delivery Day Year
ss that	by Pi	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to		te to the cause of death?
w requires to been signed should be	ted	Asbestosis					1 🗆 Y	′es 2. X No 3[Probably 4 []Unknown
	Completed	Chronic Obstructu	re Plmonan	Y Dis	ease		24a. Was autop perfor	sy prior deal	
ding Physician: The After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	spital:		- 0:	her	th (Check only o		
Phys this	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of	nt 3[]DOA	4 Nursing H		tence 6 □Other (now injury occurred	Specify)
tanding feath. tor: Afte the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2 ☐No			
al or Atta	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S City or Tox		r Rural Route Number,
To the Hospital or Attanding Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	ledical C		ian: To the best of my kno r: On the basis of examina and manner stated.						
To the within To the comp	Me	29b. Signature and title of certifier				nse number		29d. Date signed (A	
,2		30. Name and address of person who seem	pleted cause of death (Item	n 23a) (Tvoe	2:	5-000		July 8	, 2005
1		Carolyn K. Wang		Sinai	Hospital	of Bultime	ore		
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Hegistrar's Signa	ture	arde	of Bultime			

Registrar

JUL 1 2 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 15 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month June Year **Physician** 23 2005 Kathleen Driscoll Alpert /Medical 4c. County of Death Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional NICOMICO Social Security Number men If Under 1 Year | If Under 24 kirs. Birthplace (State or Foreign Country) 6 Sax 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Hours Min 1 ☐ M 2 💆 F 85 219-07-6246 10/22/1919 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28e-1 show other treumetic event, the Medical Examiner must be nutified at 1 XYes 2 □ No Maryland Directo Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 21804 210 Washington St. USA permit. Pages 1 and 2 should be filed within 72 hours atter death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature" any injury or other treumetic event by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Shirt Factory Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Horner Elmira Inslev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Wilkins/daughter 210 Washington St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial *4 □Donation 5 🗷 Other (Specific ntombment 6/28/05 Salisbury, MD Park 21. Signature of Funeral Service Licensy Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that Jused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brainston **Physician** day s disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death 9 Unknown certificate has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerel (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D41721 23/05 MD of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address PAYLOS SALISBURY 21804 STEPHAN YOU E, SHORE OR 31. Date filed (Month, Day, Year) strar's Signature State JUN 2 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State 6-28-05 Amend#29d.Per Phys.PG Certificate of Death Reg. No. () () 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9:15 AM Allen 05 BenNICE 14 /Medical 4c/ County of Death 4b. City, Town, of Location of Death Aa.\Facility Name (If not institution, give street and number) **Examiner** Dashington Hoventist contgomeri If Under 1 Year If Under 24 Hrs.

18 Date of Birth
Month, Day, Year 9 9 lahoma tark ttosorta 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 579 32.5280 1□M 2 F Yrs. Deneca Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location County or 28a-1 show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It has 23 or 28e-1 show item 2.72 In marked other than "natural", or Itams 23e or 28e-1 show other traumatic event, Ita Madical Extending the motilized at pattsville 1 Yes 2 □ No MD rince beardes Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Gountry? 4922 ruted **rates** DAD 20782 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: f Yes, Give Year or Dates: Dlach 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) luxse 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Uglesbu Growner Jebstev 2 19b. Mailing Address (Stree and Number or Rural Prute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pring permit. Pages 1 and 2 Department of Health at Important; If item 27 la any injury or othar trak once. Moore 26 MU 2601 Washing tavalp legnew MEN 20b. Place of Disposition (Name of Method of Disposition cemetery, crematory 1 Surial 2 Cremation 3 Pemoval from State handover Mary Jan Memorial 2005 ttarmonul ^ 4 □ Donation 5 □ Other (Specify) Khines Funcial 21. Signature of 22. Name and Address of Facility uneral Service Licentee bttn Washington LOOLI 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreaded, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Im I diate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician 6/16/05 /Medical **Examiner** Obs Muchus induce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed mbolble attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ian/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Physic been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗆 No certificate 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Yes To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 2 No 1 Tes 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Cartifier Medical (Check only one) and manner stated

State Registrar

31. Date filed (Month, Day, Year) JUN 2 8 2005

29b. Signature and title of certifier

Name and address of person

lathalle

cause of death (frem 23a) (Type (Frint)

ayro

remisse

ORIGINAL

29c. License number

00060443

lathonia tark

29d. Date signed (Month, Day, Year)

6/17/05

			1 - For State Registrar	State of Ma		artment of I		Mental Hygie	ene 	22657		
I	Physici	an	1. Decedent's Name (First, Middle, Last)	- 1-				2. Date of Death Month	Day Year	3. Time of Death		
	/Media	al	Mary Gertrude			T 2 2		June 23	, 2005	11:00 a ^M		
	Examir	er	4a. Facility Name (If not institution, give st Westminster Nursi		ab Ctr		or Location of Dea minster	ath	4c. County of Death	roll		
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr			place (State or Foreign untry)		
	Director		212 01 24-11	M 2√2 F	90 Yrs.	Months Days	Hours Mir	Nov 15,		yland		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Mary a-f sh	tor	Maryland Carrol	1			Hampste	ad	1 ☐ Yes 2 反 N			
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show dical Examination or diffed at	Funeral Director	10e. Street and Number			10f. Zip Code		10g	0g. Citizen of What Country?			
	s 23a	rail	4288 Northwoods T		-		21074		USA			
.	fter de	Fune	11. Marital Status 12 Never Married 2 Married 13	 Was Decedent 8 Armed Forces? 1 ☐ Yes 2 X N 		Was Decedent of H If Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White			
ğ	ours a ral', o Enan	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 № No	Specify:		Specify:	WHITE		
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ya	should be nd Mental marked c	ToE	William Chenowith					lie Rhodes				
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type Helen Torres, step					iural Route Number, C Manchestei				
	s 1 and r Health item 27 other tr		20a. Method of Disposition	Maugricer	20b. Place of Dispo	-			c. Location - City or T			
E C	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State		Crematic	0.01	27/2005	Hampstead	l, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Licensed	Eline Fund t, Hampstea		174						
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687	ificate g phys as the	edlcai	d.						No. 1 reserve com 17			
Вох	death certifici e attending pl d for use as t	an/M	23b. Was decedent pregnant	c. If yes, outcome of		Ectopic pregnancy	,		23d. Date of deliv			
O.		Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at 9□Unknown		Other (specify)		rja.	Month	Day Year		
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ecc	e law n has be ge 2 sh	Completed						24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of		
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n ot	ding Ph h. After thi funeral	T :uc	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day	v 28b. Time of			28d. Describe how i		(9)		
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	0	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	cian: To the best o	of my knowledge, death	occurred at the tin	ne, date and place	e, and due to the cause	e(s) and manner as s	tated.		
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	5 1 × 5 × 5	_	29b. Signature and title of certifier	h. 11	10.7	29c. Licens	e number	29d.	Date signed (Month,			
	Mor		30. Name and a dress of person who com	pleted cause of de	egth (Item 23a) (Type,	Print)	174	5 61	23/20	(0)		
			John W. M	iddle +	m 68	8 Pod	e Rd,	Wester	unster o	40 21157		
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			For 1 - State Registrar	S	tate of	Marylar	id / Depa	artmer	nt of H			ental Hy	/giene	_		22658	
			Decedent's Name (First, Middle	, Last)								2. Date of D				3. Time of Death	_
	Physici		1	7	R							Month	2.7				М
	/Medic Examin		4a. Fecility Name (If not institution	, give stre	et and numb	er) 9 9		4b. City	, Town, or	Location o	of Death	June		. County of E		13 9 7	_
		•	Shady Grove Ad	venti	st Ho	snital		Ro	ckvi1	16			10	lontgo	ners	7	
	Funeral		5. Social Security Number	6. Sex	7.		last birthday)		r 1 Year	If Under 2	24 Hrs. Min.	8. Date of B (Month, D				ace (State or Foreig	gn
п	Director		264-38-4960	1 □ M	2 X F	75	Yrs.	MOTITIS	Days	Hours	Will.	10/17/			Ohic		
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g	el', o	by	3 X Widowed 4 ☐ Divorced		If Yes, Give Year or Date	95:		1 ☐ Yes	2 X №	Specify:				Specify:	Whi	te	
9	within 72 hours after death with the Maryland ene. then "neturel", or Iteme 23s or 28s-f show for Medical Extraiter notes be notified at	Completed	15. Deceden (Specify only higher	's Education	on moleted)		16a. Dece	dent's Usu	al Occupa	ation during most	of working	10	16b. K	ind of Busine	ess/Ind	ustry	_
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ž	ould Mer narke	٩	Maurice Mowrey									icksor					
Maryland 21215-0036	12 sh h and 7 Is m raum		19a. Informant's Name/Relations		Print)							l Route Numi				Code)	
ď	1 and 16altl		Jeffrey Biggs - 20a. Method of Disposition	Son		20h F	5309_Place of Dispo			1s Cc		Columb				- Chan	_
20	2 = 10 ge		1 ☐ Burial 2 ☑ Cremation	3 Remo	oval from St	ate	emetery, crei	matory or	other place	.				ocation - City			
Baltimore,	it. Pg rtmer rtent njury		`4 □ Donation 5 □ Other (S			Ft.	Linco							ntwood	1, N	ID	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examination and page.		21. Signature of Funeral Service	LICEDEDE	Xm	ما	H.1	ines-	Rina New	ldi Fi lamps	unera hire	al Hom	e, II	nc r Spri	ng,	MD 20904	+_
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ă	death atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No			n 2 ∏ Feta It at time of d		Ectopic p						Month		Day Year	
o.	at the de by the a tached	hysi	9 Unknown		9□ Unknow	n											
٠ <u>٠</u>	res that igned to be det	by P	Part II. Other significant condition	ns contrib	uting to deat	h but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did	tobacco	use contribut	e to the	cause of death?	
2	w require been sig should b											1 🗆	Yes 2	□No 3□] Proba	bly 4 🏋 Unknown	n .
Records,	s bee	Completed										24a. Wa:		24b. Were	autop	sy findings available	е
	The lav	E O											ormed?	deat	h?	pletion of cause of	
ta		a	25. Was case referred to medical							26. Place	of Death	1 Yes		1 10	185	2 L 140	
>	.s b	To B	examiner? 1 ☐ Yes 2 X No	Hosp	oital: 1 ½ Inp	atient 2 🗆	ER/Outpatier	nt 3 🗆 D	Othe	r: 4 □ Nui	rsing Hon	ne 5 Res	idence	6 Other (S	Specify)		
Division of Vital	ding Ph h. After th funeral	Certification;	27. Manner of Death 1 X Natural 5 □ Pendin	g	8a. Date of (Month,	Injury Day Year)	28b. Time of Injury	M	28c. Injury Work	at ?? /es 2 □ h	2	8d. Describe					
<u>S</u>	Attender death	lica	2 Accident investig	not be	Se Place of	Injury - At he	ome, farm, str			03 2 01		8f Location	Street ar	d Number o	r Rural	Route Number.	_
2	after after Dire	erti	4 Homicide determ	illeu –	building	, etc. (Specif	y)		,,			City or To					
	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After mpletely filled in by the fune		29a. Certifier 17 Certifyin	g Physicia	n: To the be	est of my kno	wledge, death	n occurred	at the tim	e, date and	d place, a	nd due to the	cause(s	and manne	r as sta	ted.	
	ne Ho ne Fu	edical	(Check only 2 Medical one)	Examiner:	On the basi and manner	s of examina r stated.	tion and/or in	vestigation	n, in my op	inion, deat	th occurre	d at the time	, date and	d place, and	due to	the cause(s)	-
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	×	29b. Signature and title of certifier					29	c. License	number			29d. Da	te signed (M	onth, D	ay, Year)	
	01		Parl Ban	m					MDO	603	35		J	une	22	2005	
	•		30. Name and address of person	wno compl	neted cause	or death (Iten	1 23a) (Type,	Print) P						_			
	Sta	e	31. Date filed (Month, Day, Year)		Philip Reg	istrar's Signa	# 32	-	0	ney		(<i>p</i> 2	083				
	Registra		JUN 27	2005	Sente	w St	(Joseph	(I)									

			1 - For State Registrar	State of I	Marylan		artment o			R	eg. 12.	005	22659
	Physic /Medi	cal	Decedent's Name (First, Middle	BYRD	arl		4h City Town		at Breat	2. Date of Dea Month JUNE	21,	2005	3. Time of Death 2:50A M
	Exami	ner	SHADY GROV 5. Social Security Number	E ADVENT			If Under 1 Ye	ROCK	VILL	E 8. Date of Birth (Month, Day	M	ONTGOM 9. Birth	
	Director		183-40-5158 Usual Residence of Decedent 10a. State 10b. County	1□ M 2 ⊡	8 3	Yrs.		ys Hours	Min.	July26	, 19	21 Pe	ennsylvani
	h the Maryl r 28a-f sho	Director	MD Mont	gomery			thersh			1	0g. Citize	en of What Cou	1∰Yes 2□No
980	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or itams 23a or 28a-1 show avent, the Medical Exerting must be notified at	by Funerai	161 Watkin 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decede Armed Force	nt Ever in U. s? No	1	208 Was Decedent If Yes, specify C	of Hispanic O Cuban, Mexica		cify Yes or No- tican, etc.)	14	S.A. 4. Race - Amer Black, White	, etc.
21215-0036	filed within 72 ho Hygiene. other than "naturi ant, the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 11th	t grade completed) College (1-4)	or 5+)	(Give life. :	dent's Usual Oc kind of work do DO NOT use re estic	ne during mo tired)				d of Business/li Home	ndustry
Maryland	9 = 0 >	To Be	17. Father's Name (First, Middle, Inc.) Oliver A.J. 19a. Informant's Name/Relationsh	. Thomas		19b. Mailir	ng Address (Str		Minn	ie Wal	ls	,	^{p Code)} 20879
	1 and 2 Health ar tam 27 is other trau		Louisiana Jon	es-Daugh	20b. P	⊥ b ⊥ lace of Dispo	Watkin sition (Name of matory or other	IS MII	.I Ra	# 10 6	dIT.	hersbu	irg,mb
Baltimore,	permit. Pages. Department of P Important: If its any injury or of once.		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature Frieral Service I	ecity)	100	ontas 22	Cemete Name and Ad	ry dress of Faci		owden	Fun		PA Home, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)	AS.	•	o not ent	er the mode of		s cardiac or	respiratory arr			Approximate Interval Between Onset and Death
8760,	e be executed sician and s burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ								
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown		2 ∏ Fetal tat time of de	death 3	Ectopic pregna				23	d. Date of deliv Month	rery Day Year
<u>α</u>	w requires that been signed b should be deta	þ	Part II. Other significant conditio	ns contributing to death			nderlying cause	given in Part	I.		oacco use		the cause of death?
al Reco	The ate h	Completed	ALUTE RENA	L FAILV	RE		-			24a. Was an autops perform	у	24b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
Division of Vital Records,	I or Attending Physician: after death. Director: After this certification by the funeral director, p	Certification; To Be	25. Was case referred to medical examiner? 1	ation of be 28e. Place of	njury Day Year)	ER/Outpation 28b. Time of Injury me, farm, stre	28c. lr	Other: 4 N njury at Vork? Yes 2	ursing Hom 28 No	Check onl online 5 Reside 3d. Describe ho 3f. Location (St. City or Town	nce 6 [w injury o	occurred	fy) al Route Number,
	To tha Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical	one)	Physician: To the be examiner: On the basis and manner	or examinati	vledge, death ion and/or inv	occurred at the restigation, in m	time, date a y opinion, de	nd place, ar ath occurred	nd due to the ca	use(s) ar	nd manner as s lace, and due t	stated. o the cause(s)
)	To that	M	29b. Signature and title of certifier	M·D.			J	359	41	-		signed (Month,	1
	Sta Registr	_	30. Name and address of person of PURAW P. m. f. 31. Date filed (Month, Day, Year) JUN 2 7 2	THUR S	50 W	. GDn	DISMON	r DR	. #	401	RUC	RVILLE	2005 MD22852
			2 1 0 1100	TO THE	1 10	5							

			1 State	partment of Health and Mental ertificate of Death	
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date	Reg. No. 0 5 2 2 6 6 0 of Death 3. Time of Death
	Physici /Medi		babriel, Butler	Tun	
	Examir	nęr	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs. 8. Date	Baltimore
	Funeral Director		133-78-2061 12M 2DF 43 Yrs.		of Birth th, Day, Year) 9. Birthplace (State or Foreign Country) Liberia
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	continu	
	Maryla f sho	jo		er Spring	10d. Inside City Limits 1 ☐¥es 2 ☐ No
	r 28e	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with	alD	2647 Cory Terr	20902	Liberia
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian, c.) Black, White, etc.
36	urs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:	Specify: Black
21215-0036	72 hou nature	ted		edent's Usual Occupation	16b. Kind of Business/Industry
2	ithin 7 ne. hen "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	Evangel Reformed
2	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23e or 28e-1 show ent, the Medical Exercit or Indiat by notified at	e Col	12th Mi	nister 18. Mother's Name (First, M	Church
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examination and injury or other treumetic event, the Medical Examination and other treumetic event.	To Be	Abraham H. Butler Sr.	Mary Whi	
اaal	12 sho and h is ma reume			ing Address (Street and Number or Rural Route N Cory Terr Silver S	
ē,	Health Health tem 27		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date	20c. Location - City or Town, State
Baltimore,	Pages ent of ry or o		1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State	of Heaven 7/9/2005	
ä	rmit. spartm sporte iy inju		21. Signatur of Funeral Service Licen ee	22. Name and Address of Facility Snowde	en Funeral Home, P.A.
B	99 = 9			46 N. Washington St	
Ē			23a. Part1. Enter the disease or complications that caused the death. Do of er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respirate	ory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		14 days
H	Examiner		Due to (or as a consequence of):		
	Z :	iner	Sequentially list conditions, and any leading to intrinculate cause. Enter Underlying Cause (Disease or injury		
	and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		
8760	ficate be executed physician and s the burial-transit	dical E	d		
9	rtificat ng phy as th	Medi	IF STANKS	7.5	
Box	death certifi e attending p od for use as	lan/N		□Ectopic pregnancy	23d. Date of delivery
o.	ires that the de signed by the a I be detached f	by Physiclan/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 [9 ☐ Unknown 9 ☐ Unknown	Other (specify)	Month Day Year
ď.	law requires that the as been signed by th 2 should be detache	y Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
Hecords,	w require been sig should t				1 Yes 2 No 3 Probably 4 Unknown
Š	The taw cate has b page 2 st	Completed			Was an autopsy findings available prior to completion of cause of
Vital	icien: The certificate harector, page	e Co	25. Was asso referred to medical	1 □ Y	
	S 0 5	OB	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatie	26. Place of Death Check of nt 3 DOA Other 4 Nursing Home 5	nalv one) Residence 6 □Other (Specify)
n of	ng Phy fter thi neral	J. Ho	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		ribe how injury occurred
UIVISION	ttending F death. tor: After the funera	catle	2 Accident investigation	M 1 Yes 2 No	
<u>≥</u>	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ertification;	4 Homicide determined determined building, etc. (Specify)	reet, factory, office 28f. Locati City o.	on (Street and Number or Rural Route Number, r Town, State)
	ospite hours unerel	calC	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To the Hospitel or within 24 hours after the Funerel Discompletely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	ivestigation, in my opinion, death occurred at the ti	ime, date and place, and due to the cause(s)
		_	290. Signature and time of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	ν		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	June 13 2005
			Ana Sanchez MD 22 South Career	P. Street Baltimore N	10 21201
**	Star Registra		31. Date filed (Month, Day, Year) JUN 2 7 2005 32. Registrar's Signature	de	
7.5	ricgisti		JUN A I COUS MOUNT IN	1977	

			1 - For Registrar			nd / Depa	artment of H	lealth a		ental Hy	giene	-	22	662
	Physici	an	Decedent's Name (First, Middle,	Last)			timouto or i	Jean	2	2. Date of De. Month			3. Time	of Death
	/Medic	al	Gertrude Greens 4a. Facility Name (If not institution,	-	er)		4b. City, Town, or	Location of		June	24 4c.	2005 County of Dea		15 P M
		d.	Manor Care Betl				Bethesd				M	ontgome	ry	
· Par	Funeral Director		5. Social Security Number 114-12-5493	6. Sex 7 1 ☐ M 2 🙀 F	Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da	y, Year)			e or Foreign
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	eation		- Ut	ct. 3,	191	b rer	ndale,	
	Maryl	tor	MD Montgor	nerv		ver Sp								City Limits
	with the	Director	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Co	untry?	
	me 23	eral	706 Bonifant St	12. Was Decede		.S. 13.1	20910 Was Decedent of Hi	ispanic Orig	iin? (Speci			ed Stat		
36	or Ite	by Funeral	1 Never Married 2 Marrie	If Yes, Give	No No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 250€No	n, Mexican, Specity:	Puerto Ri	can, etc.)		Black, Whit		
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. ad othar than "natural", or Iteme 23e or 28e-f ahow event, Ita Mazical Eramine must be mailled at	ted b	3 Widowed 4 □ Divorced 15. Decedent's	Year or Date	OS:	16a. Deced	dent's Usual Occupa	ation			16b. Ki	ind of Business		
121	within 7 ne. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of work done of DO NOT use retired	during most)	of working				1	
g 5	filed Hygi othar	Be Co	17. Father's Name (First, Middle, L	ast)		Reta	il Owner	18. Mother	's Name (i	First, Middle,		thing Sumame)		
Maryland	2 should be 1 and Mental I Is markad or raumatic eve	To B	William Greensp					Mo11	y Tie	eger				
Mar	id 2 shi lth and 27 Is m traum		19a. Informant's Name/Relationshi				ng Address (Street a				-			
Baltimore,	of Head		20a. Method of Disposition 1 XBurial 2 Cremation		20b. P	/ UO _B Place of Dispo emetery, cren	onifant S sition (Name of natory or other place	e)	Dat			cation - City or		
Ĕ	t. Pag rtment rtent: I		* 4 □ Donation 5 □ Other (Spe	ecify)		deph S	holom	Ju				rfield,		
Ba	permit. Pages 1 and 2 should by Opparational of Menia Important: If Item 27 is marked any injury opother traumatic ence.		21. Signature of Furieral Service Li	Alway (10		Name and Addres New H							
	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Arterio Due to (or a	oscler as a consequ yroidi	otic H uence of): sm	er the mode of dying		eardiac or r	respiratory ar	rest,		Approxim Interval B Onset an	letween
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dementi	as a consequ	uence of).								
	ate be executed hysician and he burial-transit	ical	resulting in death) Last	Due to (or a	as a consequ	,	e Pulmona	ry Di	sease					
O. Box 68	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)				2	23d. Date of deli Month	very Day	Year
ds, P.	gne gne	by	Part II. Other significant condition Proptosis	s contributing to death	n but not resu	ulting in the ur	nderlying cause give	in in Part I.			bacco u	se contribute to	the cause of	
Kecords,	sw requires been size should I	ompieted								24a. Was a	an			
		e C	25. Was case referred to medical					26 Place o	of Death //	autop: perfor 1 Yes	med? 2 √ √ No	24b. Were au prior to death?	ompletion of 2□ No	cause of
ō	this big	n: To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien	Othe	r: 4 🙀 Nurs	sing Home		ence 6	Other (Spec	ufy)	
slon	Attending F r death. ector: Alter by the funera	catio	1★ Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion		Injury	M 1 7	es 2 □ No						
2	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	4 Homicide determin	ed 286. Place of I building,	etc. (Specify	′)	eet, factory, office			City or Tow	n, State)			mber,
	ne Hos ne Fund detely f	edicai	29a. Certifier Certifying (Check only one) Medical Ex	Physician: To the best caminer: On the basis and manner:	of examinat	wledge, death tion and/or inv	estigation, in my op	e, date and inion, death	place, and occurred	d due to the c at the time, d	ause(s) date and	and manner as place, and due	stated. to the cause	(s)
1	within comp	Ž	29b. Signature and title of certifier	112/04	/_		29c. License D5369					signed (Month		
	>		30. Name and address of person w	no completed cause of	f death (Item	23a) (Type I		т			June	25, 20		
			Ajay P. Reddy,	M.D. 6320	Democ	racy B	lvd. Beth	esda 1	MD 20	817				
est '	Stat Registra		31. Date filed (Month, Day, Year) JUN 2 7 2	.005 Regis	strar's Signat	ture	Le P							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. [] Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** 7:25 P M Javier Barros 19 Francisco 2005 June /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Woodside Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours **™** M 2 □ F Yrs. 578-58-5623 86 3, 1918 Ecuador Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No Directo Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 9101 Linton Street Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: White 1 🕱 Yes 2 🗆 No Specify: Ecuadorian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bellman Hotel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Consuelo Calvache Juan Jose Barros 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maria America Barros/ Wife 9101 Linton Street, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) July 1 Rurial 2 XCremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2005 21. Signature of Funeral Service Licensee Francis Address & Faillins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Embolism Physician Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Deep Venous Thrombosis Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia, Depression Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 No 1 🗆 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: Will Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 🔀 No 2 1 Tyes 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical | Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 20, 2005 D32332 Mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #220, Silver Spring, MD 20902 M.D. Suresh K. Gupta, 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

Funeral

Director

יו nam צו וa marked other than "natural", or itams 23a or 28a-f ahov option traumatic avant. Its Medical Examinar היוצד לא האלווועם מו

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Division of Vital Records,

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permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than 17 is marked other than 18 is marked othe

2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. 2.005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician June 22 2005 6:15 Richard Lee Black /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3452 Residential Drive Eden Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5/25/1933 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 485-30-2399 72 Director Iowa Usual Residence of Decedent illed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23s or 28a-f show other traumatic event, the Mactical Exemples must be notified at 1 Yes 2 No **Funeral Director** Maryland Eden Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3452 Residential Drive 21822 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Mental Hygiene. arked other than College (1-4or 5+) Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be 1 and 2 should be 1 Russell is marked Black Lucille Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 3452 Residential Dr., Eden, MD 21822 Kathleen Ann Black/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' ᇹ 1 ☐ Burial 2 XCremation 3 ☐ Removal from State = 0 permit. Page Department o Important: If any injury or 6/26/05 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Cidensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocond disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the attending IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Tyes 2 No Ca uneral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Jo 2 ER/Outpatient 3 DOA this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Japital C. 4 hours after dea. 1 Natural 5 Pending 2 No 1 🗌 Yes investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by determined 4 Homicide within 24 hours a Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continu who completed cause of death (Item 23a) (Type, Print) 30 Name and address of person istrar's Signature e. JUN 2 4 2005 31. Date filed (Month, State Registrar

			1 _ State	te of Maryland /	Department of H			71115	22665
			1. Decedent's Name (First, Middle, Last)	1		Joann	2. Date of Death		3. Time of Death
	Physicia /Medic		Paul W. Bonne	tte			June .	24 2005	1020 PM
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	plece (State or Foreign
	Director		214-88-9558 15M 2	□F 38	Yrs. Months Days	Hours Min.	May 06		MD MD
	and we		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
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	or 28s	Oirec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
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ylar	Mental Mental arked c	ToE	Okey S. Bonnette			Ruth Ell	iott		·
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Printer Ruth Strzelczyk/mother		9b. Mailing Address (Street 4149 McMuller		i Route Number, neytown,		
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Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic en		21. Signature of Funeral Service Licensee		Pritts Fu	ss of Facility Ineral Hom	e and Ch	apel, P.A. inster, MD	21157
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	15		30. Name and address of person who complete	d cause of death (Item 23a	a) (Type, Print)	Anni In .	Balti	Grune	1201 (treat
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	wary of "	rary the	000	. Trull	vilcer
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Lo	cation							10d. Inside City Limits
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C	RB		30. Name and address of person with PAU A. Dec. [31. Date filed (Month, Day, Year)	IONE MAD	death (Item 23a) 42 d trar's Signature	Type. F	Print)	ing,	Rel	Hya	arbuil	le Mi	20	787
	Sta Registr		JUN 2 7 20		itrar's Signature	for	E							

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	/Medio Examir		4a. Fecility Name (If not institution, g		9r)		4b. City, T	own, or	Location of	of Death	Julie 27	1	nty of Death	J.JJ a.	
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	Funeral Director		5. Social Security Number 6. 217-12-1834 Usual Residence of Decedent	Sex 7 1 ☐ M 2 🖾 F	Age (In yrs. 83	. last birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Nov. 3,	Year) 1921		olace (State or Ford ntry) ryland	eign
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Physician Medical Examiner Part Comment Control		40200		rough 16 M	erry (F)	1 50	I SNOW H	ili Ka.	, Salisbur	y, MD 218	104
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So annitably list conditions of any leading to immediate fairy, leading to immediate f				disease or condition	a Aden - C.	arcinon	a of t	1/cgmp	a of b	Pater	1/2 705.
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The state of the s											as 2□ No
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29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signerture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	el or s afte	Sert	4 LJ Homicide	building, etc. (Sp	oecity)			City or Town,	State)	
29b. Signerture and title of certifien 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tomes E. Martin M. J. 145 E. Grall St., Jalisburg, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ospit hour unere ly fills		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, death	occurred at the tim	ne, date and pla	ace, and due to the car	use(s) and manner a	as stated.
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31. Date filed (Month, Day, Year) 32. Benistrat's Signature		5									
Registrar ///N 2 3 2005				31 Date filed (Month Day Vocal	27/N M.D.	145	E. Gre	1197.	, Deliss	ur-, m	D.
	300			171N 2 3 2	nns Sz. Fysitais S	L A					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Helen Leora Boslow /Medical JUNE 23RD, 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND
If Under 1 Year If Under 24 Hrs. ALLEGANY 5. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) Months Days Hours Min 1 ☐ M 2**X** F Yrs 1914 Pennsylvania Director 90 212-32-4613 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Grantsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 172 Hill Street 21536 USA Funeral Was Decedent Ever in U.S.

Amed Forces?
13. Was Decedent of Hispanic Origin? (Specify Yes or No. 1945 as, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other then "neturel", or Ite 1 Never Married 2 Married If Yes, Give Year or Dates: to Dec 1945 Yes 21 No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Complet (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel H. King Mary Mae Hollada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is P.O. Box 115, Springs, PA James King/Brother other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or June 26, 2005 Springs, PA Springs Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Furtheral Service Licensee Bny P.O. Box 275, Grantsville, MD 21536 ellman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner physician and the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed SEVERE PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: BSL 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death ö in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Nonknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: P 1 ☐ Yes 2 No 1 Depatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1-Watural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and To the Funerel Dir 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMAD, AFAQ, M.D. 625 KENT AVENUE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2005 Registrar

			For	State of Maryland /	•			0670
			State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death 2. Date of D	Reg. 26.005 2	25 JU 3. Time of Death
ı	Physicia			inda Chatmon		Month June	Day Year 25, 2005	9:30am ^M
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, o	r Location of Death	4c. County of Death	7.50am
		Ť	Southern Maryland	Hospital	Clinto		Prince Geo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b.	irthday) If Under 1 Year Months Days	Hours Min. (Month, I	Birth 9. Birthplac Day, Year) Country,	e (State or Foreign
	Director		219-11-4868 Usual Residence of Decedent	33		Aug. 2	29, 1969 Wash,	D. 0.
	arylan show d st	_	10a. State 10b. County		wn or Location		10d.	Inside City Limits 1 ☑ Yes 2 ☐ No
	the Ma	Directo	Maryland Prince Ge	orge Upper	Marlboro		10g. Citizen of What Country	
	3a or	Į Di	212 Prenton Stree	et		20774	United States	
	ams 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Specify Yes or Man, Mexican, Puerto Rican, etc.)	No- 14. Race - American Black, White, etc	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1 ☐ Yes 2 ☒ No	Specify:	Specify: Bla	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or itams 23a or 28a-f show avant, the Medical Examinar must be notified at avant.	ted t	15. Decedent's Educ	cation 166	a. Decedent's Usual Occup	pation	16b. Kind of Business/Indus	stry
21	ithin 7 ne. Med	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	d)	None	
2	filed w Hygier ther th	Col	12th 17. Father's Name (First, Middle, Last)		None	18. Mother's Name (First, Midd		
au	lid be ked o ic ava	To Be	Ollie Chatmon			Jean Crump		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinet must be notified at one.		19a. Informant's Name/Relationship (Ty) Ollie Chatmon/Fat		b. Mailing Address (Street 12 Prenton S	and Number or Rural Route Num St.; Upper Mar1h	nber, City or Town, State, Zip Cooro, MD. 2077	
ē,	s 1 an if Heal itam 2 other		20a. Method of Disposition	comet	of Disposition (Name of ery, crematory or other place	ce) Date	20c. Location - City or Town	n, State
Ē	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Resur	rection Ceme	teryJune 30,200	O5 Clinton, MD).
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licens	Inco MRIAN	22. Name and Addre	Korectu	neral Homes rlboro Pike ille, MD. 20747	,
			23a. Part1. Enter the disease or complishock, or heart failure. List only or	cations that caused the death. Do	not enter the mode of dyir	ng, such as cardiac or respiratory	arrest, A	pproximate Iterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	METASTAT	IC BREA	ST CANCER		Inset and Death
	/Medical Examiner		ſ	Due to (or as a consequence	e of):			
	D =	ner	Sequentially list conditions, it any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	a of):			
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	a of):			
8760,	cate be executed physician and ; the burial-transit	dical E		l				
9	rtificati ng phy s as the	Medi	IF FEMALE:					
Box	death certific e attending p id for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3 Ectopic pregnanc 5 Other (specify)	у	23d. Date of delivery Month Da	ay Year
o.	that the de ed by the a detached	ysic	1 ☐ Yes 2 A No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)			
S,	The law requires that the to be some signed by the base seen signed by the bage 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given		d tobacco use contribute to the	
ord	w require been si should I							ly 4 □Unknown
Vital Records,	The law ate has b	Completed				24a. Wi au pe	topsy prior to comp prormed? death?	y findings available eletion of cause of
ta		a	25. Was case referred to medical			1 ☐ Yes 26. Place of Death (Check onl	1	□ No
Ϋ́	di S	To B	examiner? 1 ☐ Yes 2 XNo	lospital: 1 Shipatient 2 ERVC	Outpatient 3 DOA	her: 4 Nursing Home 5 Re	<u></u>	
on of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Time of 28c. Injury Wo	ry at 28d. Describ rk?] Yes 2 □ No	be how injury occurred	
Division	tan feat tor: the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,		28f. Location	(Street and Number or Rural F	Route Number,
Ö	or A of ther of the of	ert	4 Homicide	building, etc. (Specify)		City or	Town, State)	
	rs are read and read	O			go, dooth occurred at the ti	ime, date and place, and due to the	he cause(s) and manner as state	
	Hospital 4 hours of Funaral ely filled			ner: On the best of my knowled ner: On the basis of examination a and manner stated.			e, date and place, and due to the	
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical C	(Check only one) 2D Medical Exemination (Check only one)	ner: On the basis of examination a	and/or investigation, in my of 29c. Licens	opinion, death occurred at the times se number	29d. Date signed (Month, Da	ne cause(s)
	Hospital 4 hours of Funaral ely filled	edical	29b. Signature and util or call fire 3d. Name and address of person who co	ner: On the basis of examination a and manner stated. On the basis of examination and manner stated.	29c. Licens D Type, Print)	opinion, death occurred at the times se number	29d. Date signed (Month, Da	ne cause(s)
C	Hospital 4 hours of Funaral ely filled	Medical	29b. Signature and util or call fire 3d. Name and address of person who co	ner: On the basis of examination a and manner stated. On the basis of examination and manner stated.	and/or investigation, in my of 29c. Licens	opinion, death occurred at the times se number		ne cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 8:05 PM De une /Medical 4a. Facility Name (f) not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Hospita ommunit annam George's Age (In yrs. last birthday) If Under 1 Year | If Under 24 8. Date of Birth (Month) Day, Year **Funeral** 5. Social Security Number 1 ☐ M 200 F Days Hours Min. 39 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortent: If Item 27 Is marked other then "neturel", or Items 23e or 28e-f ehow injury or other treumetic event, Ire Madical Examiner must be notified at 1 Pres 2 □ No Director lairta 10e. Street and Number 10g. Citizen of What Country? 8525 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□Yes 2DNo 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If Item 27 Is marked other then any injury or other treumetic event, Item Na College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Tohn sor larence essie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hacken sock son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Ken Sack Cemeter * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Ficility Upshar St.NW or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Examiner as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAUKEL, 575 MAW SUITE 253 STREET

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

JUN 2 8 2005

2. Registrar's Signature

			1 - State Registrar	State		nd / Depa		Health and	d Mental Hyg	•	22672
	Physici /Medio		Decedent's Name (First, Middle RONALD	e, Last)	CRUI	AP			2. Date of Dea Month JUNE		3. Time of Death 1:23 P M
	Examir		4a. Facility Name (If not institution HOLY CROS	•				SPRING		4c. County of Death MONTGOME	
	Funeral Director		5. Social Security Number 224-70-1625	6. Sex 1 M 2 ☐ F	7. Age (In yrs	. /ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day January		nplace (State or Foreign untry) GINIA
	the Maryland 28a-f show outfled at	ector	Usual Residence of Decedent 10a. State 10b. County MD PRINCE 10e. Street and Number	GEORGE'S		ORESTVI				On Chinese of When Co	10d. Inside City Limits 1 X Yes 2 □ No
	h with 23a or 3	ai Dir		ARK DRIV	E		2074	.7		0g. Citizen of What Co	untry ?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumatic svent. The Medical Examinal must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Marr 3 □ Widowed 4 □ Divorced	Armed F	2 No ive			Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036	ithin 72 ho ie. ien "natur i Medical	npieted	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	st grade completed, College	1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of d)	working	16b. Kind of Business/l	ndustry
d 21	Hygien Hygien Ither th	Cor	17. Father's Name (First, Middle,		yrs	Be1	l Captian	1	Name (First, Middle,	Private Maiden Sumame)	
/lan	uld be Mental Irkad o	To Be	JAMES CRUMP					RUE			
	nd 2 shoulth and 27 is mu		19a. Informant's Name/Relations BARBARA CRUMP/V							r, City or Town, State, Z VILLE, MARY	
lore,	ages 1 av	8	20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation			Place of Dispo cemetery, cres	sition (Name of matory or other pla	i	1.	20c. Location - City or	Town, State
Baltimore,	permit. Pa Departmen Important any injury		`4 □ Donation 5 □ Other (S		Ri	22		ess of Facility J	I. B. Jenk	Riverdale M ins Funeral r, Maryland	Home
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	a. MET Due to b. SEI Due to	caused the dereach line. CASTATI (or as a consecutive consecutiv	C LUNG	er the mode of dyi	ng, such as card	diac or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 68760,	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medicai Exa	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Ulnknown} \)	d	(or as a consection of pregions) it come of pregion of pregion of the consection o	nancy tal death 3[Ectopic pregnance	у		23d. Date of deli Month	very Day Year
	quires that the de: n signed by the a ild be detached f	by	Part II. Dther significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute to	
al Records,	n: The law require ficate has been sig or, page 2 should b	Completed	Of Was and the state of the sta							ned? prior to death? 2. No 1 □ Yes	topsy findings available ompletion of cause of
Ž	nysicie nis certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【XNo		Inpatient 2	☐ ER/Outpatier	nt 3 DOA	100	Death (Check only on g Home 5 Reside	ence 6 Other (Spec	ify)
Division of Vital	nding Pt ath. r: After the funeral		27. Manner of Death 1 X Astural 5 Pendin 2 Accident investig	9	of Injury oth, Day Year)	28b. Time o Injury	Wo	ry at rk?] Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	al or Atte s after de: al Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could determ	inad 200. Flac	e of Injury - At ling, etc. <i>(Sp</i> ec	home, farm, str cify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On the I	e best of my kr pasis of examination of stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my o	me, date and pl	ace, and due to the c ccurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifie				29c. Licens			9d. Date signed (Month	, Day, Year)
1	0		30. Name and address of person,	who completed car	Se of death /Its	am 23a) /Tuno		05606	3	6/23/US	
	NO		Brian F. R					lver Sp	ring, Mary	land 20901	
	Sta		31. Date filed (Month, Day, Year)	2.	Registrar's Sign		<i>.</i>				
	Registr	ar	JUN 2 8 21	עט כטו	w do	1000					

		-	For State Registrar	State of Ma	aryland /		artment of H		and M		iene	005	2267	13
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of D	eath
	Physicia /Medic		Nancy Anni	.e Cl	emons					June 25	Day 2	e US Year	0645	М
	Examin		4a. Faeility Name (If not institution, give	street and number)	1	. 1	4b. City, Town, o	r Location o	of Death		40,0	County of Deal	th	,
			Prince Geor	ge 5 /-	505/01	tel	Che	ver	14		10	ince	George	25
	Funeral		5. Social Security Number 6. Se 15 15 16 16 16 16 16 16 16 16 16 16 16 16 16	711 000	ie (<i>In yrs. l</i> ast 81	birthday) Yrs.	Months Days	Hours Hours	Min.	8. Date of Birth Day 04/27/	1	9. Birt	hplace (State or l buntry) Carolina	Foreign a
	Director	-	Usual Residence of Decedent	Λ (01					04/2//	1324	IV.	Caronina	2
	yland		10a. State 10b. County	-	10c. City, T	own or Lo	cation						10d. Inside City	
	B Mar	ctor	DC		Wa	shing	rton						1/1 Yes 2	≥ □ No
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Exertical most be routhed at	al Director	100. Street and Number 1100 48th Place, 1	N.E.			10f. Zip Code 2001	9		1		en of What Co J.S.A.	ountry?	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.1	Was Decedent of H	lispanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)	1.	4. Race - Ame Black, Whit		
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯 I If Yes, Give	No		1 □ Yes 2 ☑ No	Specify:				Specify: B]		
21215-0036	hour tural	d be	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		6a Doon	dent's Usual Occup	otion				d of Business		
5	in 72 " r	Completed	(Specify only highest grad	le completed)		(Give	kind of work done	during most	t of worki	ing	100. KIII	d of business	industry	
212	yiene.	E O	Elementary/Secondary (0-12) 8th	College (1-4or 5	5+)	I	omestic					Self		
Þ	be filed tal Hygid d other event, I	Bec	17. Father's Name (First, Middle, Last)							(First, Middle,		Sumame)		
/lai	should be ind Mental marked o	2	Fred Gamble					A	nnie	Jackson	n			
Maryland	and and s m		19a. Informant's Name/Relationship (T)	(-rand-			ng Address (Street						Zip Code)	
	1 and 1 Health tem 27		Tia N. Liverpool-Road	1 - Daught			Holly Hock	Court;						
0	ges 1 a it of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cem	etery, crei	sition (Name of matory or other place	'		Date		ation - City or		
Baltimore,	it. Pa ritmer ritant: njury		* 4 □ Donation 5 □ Other (Specify,		Harm		morial Cem		06/28		Lanc	bver, M	aryland	
Ba	permit. Pages. Department of the Important: If ite any injury or ot once.		21. Signature of Funeral Service Closes	Fren	an	2	P. O. Box				and	20752		
			23a. Part1. Bother the disease, or comp shock, or Heart failure. List only of	ications that caused ne cause on each li	d the death. I	Do not ent	er the mode of dyir	ng, such as	cardiac c	or respiratory ari	est,		Approximate Interval Betwee	een
	Physician		Immediate Cause (Final disease or condition	a. Can	ncer								Onset and De	adiri
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	ice of):								
Н		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequer	re of								
	ted nsit	Examine	Cause (Disease or injury	D00 to (01 23	a consequer	100 01).								
	akecu al-tra	xar	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):								
8760,	icate be executed physician and s the burial-transit	dlcall		d.										
9	tificat ig phy as th	edi												
Вох	the death certificate be executed y the attending physician and Iched for use as the buriat-transit	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnance				2	3d. Date of de		
	e dea he att	sicle	in the past 12 months? 1 Yes 2 No	4□Pregnant at 9□Unknown			Other (specify)	,				Month	Day Ye	ear
P.0	that the de ed by the a detached t	Phy	9 Unknown							00. 5:11				
	es De	by	Part II. Other significant conditions co		out not resultir	ng in the u	nderlying cause giv	/en in Paπ i	•		es 2		o the cause of de- robably 4	nknown
Vital Records,	w requir been si should	Completed		,						-				
360	has has	шb								24a. Was autop	sv	prior to death?	utopsy findings av completion of cau	variable use of
a										1 ☐ Yes	2- No		2 □ No	
	Ser Ser	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatio	20/50	VOutpatie	nt 3 DOA Ott	200		(Check only of				33
of		H .	27. Manner of Death	28a. Date of Inju	ury 28	3b. Time o	IL SU DOA	4 🗀 140		me 5 Resid 28d. Describe h			есту)	
ion	Attending I r death. actor; After by the funer	atloi	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	iy Year)	Injury		rk? Yes 2 🗌	No					
Division	if or Attendi after death. Director: A d in by the fu	tific	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of In	jury - At home	ə, farm, st	reet, factory, office			28f. Location (S City or Tow			ural Route Numbe	er,
Ö	tator is afte al Dire	Certification;	T I Normaldo	bunding, en	to: (Dpschy)					0119 01 1011	n, olale,			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	rsician: To the best iner: On the basis of and manner st	of examination	edge, deat n and/or in	h occurred at the ti vestigation, in my o	me, date ar opinion, dea	nd place, ath occurr	and due to the ored at the time, or	ause(s) a date and	and manner a place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	, 4			29c. Licens				-	signed (Mon		
)			Harador ,	Alas	to i	00	150	055	97	-7	Ju	ne 20	0, 2005	
10	2(8)		30. Name and address of person who o	ompleted cause of	death (Item 2	30	2.0	0 >	2			/		/
4	0		SALVA dor Dy	rester	3001		spita	(D.	100	e, c	صها	rly,	Mary 1.	ANd
	Sta Registi	-	JUN 2 8 2005	2. Registr	rar's Signatur	Spe	de la			,		• *		

	•	1- For State of Maryland / Department of Health and N Certificate of Death		ne 2005 22674
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Theodore Matthew Deaver Carter	2. Date of Death Month JUNE 26,	Day Yeer 3:32 A M
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UNION HOSPITAL ELKTON		4c. County of Death CECIL CO
Funeral Director		5. Social Security Number 217 13 3319 G. Sex 10XM 2 F 7. Age (In yrs. last birthday) 18 Yrs. Hunder 1 Year If Under 24 Hrs. Months Days Hours Min. 18 Yrs.	8. Date of Birth (Month, Day, Ye Jan. 7,19	
es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-1 show r other traumatic event, the Medical Evantical must be notified at	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location	Decify Yes or No- Decify Yes o	ity or Town, State, Zip Code) [aryland 21901 5. Location - City or Town, State
permit. Pages Department of Important: If it any injury or o		200 21. Signature Funda advice Lice see 22. Name and Address of Facility C1	rouch Fune eet,North	East, Maryland 21901
/Medical Examiner prize per prize pe	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or flu), that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):		Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
quires that in signed t uld be deti	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?
	e Completed	25. Was case referred to medical 26 Place of Dea	24a. Was an autopsy performed	
dis y	To B	examiner? Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA Other: 4 Nursing Hospital:	th Check only one ome 5 Residence 28d. Describe how i	e 6 □Other (Specify)
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	28a. Date of Injury Section Content	Subject	was Stabled It and Number or Rural Route Number, Italian Number of Rural Route Number, Italian Number of Rural Route Number,
e Hospi 24 hou e Funer etely fill	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier 29c. License number OCME		Date signed (Month, Day, Year) UNE 26, 2005
3 Sta Registr	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenbary M.D. 111 Penn Street 31. Date filed (Month, Day, Year) IIIN 2. 8 2005	t Baltimo	ore, Maryland 21201

			1 - For State Registrar	State of Marylan		artment of F			ene - N2 0 0 5	22675
	Physici /Medic		Decedent's Name (First, Middle, Last)	FAY LOU	ISE	CLEGG		2. Date of Death Month	Day Year 3 , 2005	3. Time of Death 6:50 A
	Examin		4a. Facility Name (If not institution, give str. 120 E. GREEN ST			WEST	r Location of Death		4c. County of De	ath L
	Funeral Director		5. Social Security Number 215-54-3776 Cusual Residence of Decedent	7. Age (In yrs. 5.5	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 19/10/1	9. Bi 949 MA	nthplace (State or Foreign Country) RYLAND
	Maryland	tor	10a. State 10b. County MD CARROLL	1	y. Town or Lo	cation INSTER			-	10d. Inside City Limits 1 Yes 2 No
	h with the 3a or 28a	al Director	10e. Street and Number 120 E. GREEN ST	•		10f. Zip Code 2115	7	10	g. Citizen of What C	Country?
980	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23e or 28e-1 show any injury or other traumatic event, Ite Modical Examiting must be notified at once.	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Microroed	. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify: WI	ite, etc.
21215-0036	d within 72 ho jiene. ir then "natur IIIe Madicel	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired CUS	during most of world	king	EDUCATION	,
Maryland	uld be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) KENNETH	STO	NESIF	'ER		e (First, Middle, Ma E I . BO		
, Mar	and 2 sho ealth and m 27 Is ma			DAUGHTER	1020	NICODE		REISTE		Zip Code) MD • 21136
Baltimore,	. Pages 1 tment of H tant: If Ital		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Ren 1 □ Donation 5 □ Other (Specify)	oval from State	LUTH		ER CEM.	6/27/05		ISTER, MD.
Bai	permit Depar Impor any in		21 Signature of Funeral Sorvice Licensee		2	54 E. M	AIN ST.		ISTER, M	D. 21157
}	Physician		23a. Part1. Enter the disease or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.				or respiratory arres		Approximate Interval Between Onset and Death
	/Medical Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ						
8760,	icate be executed physician and s the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
x 687	eath certificate attending physi I for use as the	/Medical	IF FEMALE:	. If yes, outcome of pregna	001					
P.O. Box	that the death led by the atten detached for u	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
ords, P	w requires that been signed I should be det	ed by P	Part II. Other significant conditions contri		alting in the us	nderlying cause give	en in Part I.		cco use contribute t	o the cause of death?
Division of Vital Record		Completed						24a. Was an autopsy performs	DI TOLIGI	utopsy findings available completion of cause of
f Vita	Physician: The la r this certificate has aral director, page 2	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 No	pital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe		th (Check only one)	ce 6 ☐Other (Spe	ecify)
sion o	ending Pt sath. or: After th	Certification:	1 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. Describe how		
<u>X</u>	urs after d urs after d ural Diract	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	') 			City or Town,		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical	one)	ian: To the best of my know : On the basis of examinat and manner stated.	wledge, death ion and/or inv	estigation, in my op	oinion, death occur	red at the time, date	and place, and du	e to the cause(s)
)	WIN .		29b. Signature and title of certifier	ort, m.D.			F D / J'S".	5-2	Date signed (Mon.	
	W 6			n+2, M.D.	5-5-5	S. CRL	ter St.	West	vinster,	Md. 21157
•	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 2 7 20	32. Registrar's Signat	A A	book				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ETHEL ELIZABETH COOK JUNE 22, 2005 /Medical 12:45 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CARROLL LUTHERAN VILLAGE WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Months 213-05-7523 Director 97 11/17/1907 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1X Yes 2 □ No MD CARROLL WESTMINSTER Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 ST. LUKE CIRCLE 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. filed within 72 hours after ☐Yes 2X No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TUBERCULOSIS Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY 12 ASSOCIATION other permit. Pages 1 and 2 should be file Department of Health and Mental Hy. Important: If Item 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THEODORE CUMMINGS ANNIE BABYLON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY RICKETTS -DAUGHTER 14 GONI TERRACE, WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 21. Sgnature of Fine al Service Licensee BAUST CHURCH CEM. 6/25/05 WESTMINSTER, MD. 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rona ularu disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): ettending physiclen and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 18 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his After the funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the efter deatl Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only igna/ are and title of certifier who completed cause of death (Item 23a) (Type, Print) POOLE Fol. WEST ENSTER D.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State	State of N	Maryland / Dep	artment of He			ene . 2005	22677
	e		Registrar 1. Decedent's Name (First, Middle, I	Last)		rincate of D	Galli	2. Date of Death		3. Time of Death
	Physici		Joseph Vincent	Coleianne				Month June	Day Year 2005	11:39 a ^M
	/Medi Examir		4a. Facility Name (If not institution, g			4b. City, Town, or L	ocation of Death	ULLE	4c. County of Death	
			Carroll Hospita	al Center			unster		Carro	11
п	Funeral			. Sex 7. / 1 SarM 2 □ F	Age (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		220-14-4123 Usual Residence of Decedent		92 "			March 1	9 1913	MD
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Mar	ctor	MD Carro	011	Westm	inster				1 ☐ Yes 2 ☐ No
	hours after death with the Maryland tural', or Items 23a or 28a-f ehow al Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	s 23a		10 South Tanne			211			USA	
	Item	Funerai	11. Marital Status 1 □ Never Married 2 Married	12. Was Deceder Armed Force 1	s?	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White	
980	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1☐ Yes 2☐ No	Specify:		Specify: Wh	ite
21215-0036	72 hours natural', dical Exe	Completed	15. Decedent's (Specify only highest of		16a. Dece	edent's Usual Occupati	ion	1	6b. Kind of Business/Ir	ndustry
2	d within 72 ho piene. r than "natu ine Medical	mple	Elementary/Secondary (0-12)	College (1-4a	or 5+)	kind of work done du DO NOT use retired)	ing most or works		Self Emplo	rod.
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Maryland	e d ala	o Be	Vincent Coleianr			'		a D'Ital		
ary.	E E	ပ	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street an			City or Town, State, Zi	o Code)
	1 and 2 s Health ar iem 27 is		Alberta Coleiann	ne/wife		South Tann				21157
Baltimore,	es 1 and of Healt litem 2 rother		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place)) [ate 2	Oc. Location - City or T	own, State
Ĕ			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contr	Mausoleum		Park Ceme	tery 6/	24/2005	Baltimore	, MD
Salt	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Lic	ensee	2	2. Name and Address Pritts Fun	of Facility	e and Ch	apel, P.A.	
	70 F 4 0		23a. Part 1. Enter the disease, or co							21157
	1 10-		SHOOK, OF HEAR FAILURE. LIST OF	iy one cause on each	line.	ter the mode of dying,	Such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a Cer	elmous w	w tte	ciden	<i></i>		Days
	Examiner			Due to (or a	as a consequence of);	- 4. /	121-01			0.
		ية	Sequentially list conditions if any, leading to immediate	b. Due to (or a	as a consequence of):	stihal	BIEED	7/2	ji, iii,	2095
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, 0	be executed sician and burial-transit		resulting in death) Last	1	as a consequence of):					W
8760,	ate hy:	dicai		d. Hac	he Sten	05/5			-	Tell>
9	eath certific attending p	lan/Mec	IF FEMALE:	23c. If yes, outcom	ne of pregnancy					
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
0	at the de by the a	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
s, P	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	s contributing to death	but not resulting in the	ınderiying cause given	in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ıd	w require been sig should b							1 ☐ Ye	s 2 pono 3 □ Prol	bably 4 Unknown
9	aw Is b	ompieted						24a. Was an		opsy findings available empletion of cause of
<u> </u>	Th ate pag	Con						perform		2 □ No
Vital Record	Physician: This certificate all director, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death	(Check only one)	
of	Phys r this ral dia	2	1 Yes 2 No	28a. Date of Ir			4 Nursing Hor	ne 5 Resider	nce 6 Other (Special	(y)
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	tal or	Cert	4 - Homicide	bullaing,	etc." (Specify)			City or Town,	State)	
	Hospital or Att 24 hours after de Funeral Directe etely filled in by t		29a. Certifier Certifying	Physician: To the be	st of my knowledge, dea of examination and/or in	th occurred at the time	, date and place, a	and due to the car	use(s) and manner as s	stated.
	\$ 5 £ 6	Medical	one)	and manner	stated.					
\	To To con		29b. Signature and title of certifier	111		29c. License	number	29	d. Date signed (Month,	uay, rear)
7	M		30 Name and address of person wh	ON IN	f death (Item 23a) (Type	()00 S	> 8/3		6/21/0	>
	MALL		Wilbur Kus	295 St	one Ano	5+ 307	Whit.	nneta	MO 21	157
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signature	, , , ,	WYZIN	716	1000	
	Registi	ar	JUN 2 2	2005	own &	book				

JET 05-04145 Rayn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

non	d John	Со	lonna 1 - State	State of Marylar					_	-	
			Registrar		Ce	rtificate of	Death		Reg. No.	005	22678
	Physici	an	Decedent's Name (First, Middle, La					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		RAYMOND JOHN	COLONNA				June	17	2005	2:51 P ^M
}	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c.	County of Dea	ath
			40365 Busy Corner		1 11:41	Leonard				. Mary	
	Funeral			Sex 7. Age (In yrs. XIXM 2□F	Yrs.	Months Days	Hours Min.	8. Date of Bi	ay, Year)		irthplace (State or Foreign Country)
	Director		219-90-6779 Usual Residence of Decedent	44			Jk	OCT.1	8,19	360 WA	ASH.,DC
	/land		10a. State 10b. County	10c. Ci	ty, Town or L	ocation			-		10d. Inside City Limits
	Man	to	MARYLAND ST.	MARY'S LE	ONARI	ОТОИИ					1 ☐ Yes 2 📉 No
	h the	Director	10e. Street and Number			10f. Zip Code			_	zen of What C	•
	hours after death with the Maryland lural; or Items 23a or 28a-f show al Ezant at must be multied at		40365 BUSY COR	NER RD.		2065	0		J	J.S.A.	
	Items	Funerai	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 1	14. Race - Arr Black, Wh	nerican Indian,
9	or It	F	1 Never Married 2 Married	1 □Yes 2 🕅 No If Yes, Give	ļ	1 ☐ Yes 2 / □ X \lo	Specify:	,,			
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						v	VHITE
5	72	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup Brind of work done DO NOT use retires	pation during most of work d)	ing	16b. Kir	nd of Busines	s/Industry
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d 2	Hygi Hygi other		17. Father's Name (First, Middle, Last	t)	LCARI	PENTER	18. Mother's Nam-	в (First, Middle			RNMENT
lan	Hental Rental rked c	To Be	JOHN KELLY CO	LONNA			PEARL I	MARIE	NIMN	MERICE	HTER
Maryland 21215-0036	s 1 and 2 should b f Health and Ment item 27 is marked other traumatic e	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (Street	and Number or Run	al Route Numb	ber, City or	r Town, State,	Zip Code)
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re,	es 1 a of He of He fitem		20a. Method of Disposition		Place of Disp	osition (Name of amatory or other place	ce)	Date	20c. Lo	cation - City o	or Town, State
Ē	Pages nent of nnt: If it ury or o		1XQ §urial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci	_Hemoval from State	-	CH EPIS.		22-05	CHI	OT OTH	TE HALL, MD
Baltimore,	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Lice		2	22. Name and Addre	ss of Facility				пошини
<u> </u>	89 = 29		Michael	V.Xz			FUNERAL MARYL				
п			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the dea / one cause on each line.	th. Do not en	nter the mode of dyin	ng, such as cardiac	or respiratory a	arrest,	,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conse	quence (i):						
	LAdillillei		Sequentially list conditions,	b		11_11_					
\mathcal{I}	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury	Due to (or as a conse	quence or):						
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ox (leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregr	ancy					23d. Date of d	elivery
B	eath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fet 4☐Pregnant at time of		☐Ectopic pregnance ☐ Other (specify) _	у			Month	Day Year
O.	that the de ed by the a detached	Physician/Me	9 Unknown	9□ Unknown							
T	es that igned b	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
rds	.≅ ∽ ¬¬	ed b						1 🗆	Yes 2	XNo 3□F	Probably 4 Unknown
ecord	faw requasis been 2 should	Completed						24a. Wa		24b. Were	autopsy findings available
\mathbf{x}	The la	mo						perf	opsy formed? 2 \(\square\) No	prior to death?	completion of cause of es 2 \sum No
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f V	lysici lis cer direc	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ott				6 ▼ Other (Sp	ecify)Scene
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	the Hospital or Attendi hin 24 hours after death the Funeral Director: A mpletely filled in by the to	ical	(Check only 2 - Medical Exe	hysician: To the best of my primer: On the basis of examin	owledge, dea ation and/or i	ath occurred at the ti	me, date and place, opinion, death occur	and due to the	e cause(s) , date and	and manner a	as stated. ue to the cause(s)
	thin 2, the post of the post o	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens					nth. Dav. Year)

To the Hospital or within 24 hours after To the Funeral Director Completely filled in It

OCME

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street

June 18 2005 Baltimore, Maryland 21201

2+1

31. Date filed (Month, Day, Year)

JUL 1 1 2005



Registrar

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Description From Print, Worth, Last Early Product of Cline Story Print Story P				1 - For State o	f Maryland / [rtment <i>tificate</i>			and Me		giene	05	22679		
Figures Security Number Control Centers Security Number Co											Month	Day	Year			
Second section without Similar	}			4a. Facility Name (If not institution, give street and num	mber)		4b. City, To	own, or	Location o	of Death						
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William Harlan Cline Stella May Heffner	2	Pages 1 and 2 should be filed nent of Health and Mental Hyg ent: if item 27 is marked othe ury or other treumatic event,		17. Father's Name (First, Middle, Last)	don	nest	ic he	1p	18. Mothe	r's Name				ldence		
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106 East Church Street, Frederick, MD 21701 April 106 East Church	Ë															
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Part of the control	00		olete	assistant assistant							autopsy prior to completion of cause of death?					
26. Place of Death (Check only one) 27. Manner of Death Shatural 28a. Date of Injury M M 28d. Describe how injury occurred 28d. Describe how injury occu	E S		E O													
Manner of Death Setate Security Securi	ital		· O	25. Was case referred to medical 26. Place of Death (Check only one)												
State Stat	<u>></u>		၉	2 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify)									y)			
29a. Certifier (Check only one) 29b. Signature and ditte of certifier 29b. Signature and ditte of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Ptr., Year) 32. Figistrar's Signature			lon;	Table and the second se								28d. Describe how injury occurred				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cashia Cassat (a) 9th Avenue Francus KMD 21716 State 31. Date filed (Month Par, Year) 2005 32. Pigistrar's Signature				(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caroline Cossert (00 9th Avenue Franço 2KVND 21716 State 31. Date filed (Month Pay, Year) 2005 32. Figistrar's Signature		To th withir To th comp	Me	29b. Signature and title of certifier	0					***		_ } , ~		Day, Year)		
State 31. Date filed (Month Day, Year) 32. Engistrar's Signature)			I Clark The	soupe	7	~	10			-	7/3/6	5			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 lune Naomi Ruth Coleman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, May 1, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 70 Director 1935 Maryland 217-32-6425 death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show or other traumatic evant, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 918 Salem Avenue 21740 U.S.A. or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced 'natural'. White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Personal Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Laura Ruth Cline Richard Alvey Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If itam 27 is eny injury or other traconce. 918 Salem Avenue Hagerstown, Maryland 21740 Earl W. Coleman / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park June 23, 2005 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician d disease or condition resulting in death) /Medical Due to (or as a Examiner tatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2 🖃 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? death? 1 ☐ Yes 2 \ No 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Tyes 2 🗌 No death. 2 Accident Diractor: 3 🗌 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarel D 29a. Certifier 1 🗸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 5826 who completed cause of death (Item 23a) (Type, Print) 110 31. Date filed (Month, Pay, Year) 2 3 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended items 10b & 19a per Certificate of Deathfh/wichd/7-6-906/0195 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Phoebe Clinton illian スの 7005 June /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ninsula Regional Medical If Under 1 Year If Under 24 Hrs. Wiconucc 13 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days S# 123 1 ☐ M 201 F Hours 172-24-2733 Director 02 LOLOLO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Marylan thit and Mantal Hygiene. 27 is marked other than "natural; or ftems 23e or 28e-f show traumatic event, the McGleal Extensine round be notified at traumatic event, the McGleal Extensine. Philadelphia Philadelphia 1 Yes 2 □ No Director tennsylvailia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street United States of America 6121 Noble 19139 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give / Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 __,Never Married 2 __ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ØWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and 2 should be ealth and Mental William Ralph Fletcher Poole Jenny 19b. Mailing Address (Street and Number or Rural Route. Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) daughter 6121 Noble St, Phila delphia permit. Pages 1 and 2 Department of Health at Important; If Item 27 is any injury or other trau once. Baldwin Thereson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature Fureral Service Licenses

22. Name and Address of Facility Terry Funeral Home
4203 it avertered free
Philadelphia PA 19109

23a. Part. Enter the stease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final 3 Removal from State Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 S es 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Contying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Continued Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) DS mileted cause of death (Item 23a) (Type, Print) 30. Name and address of person who are Chris Styder Do 100 E. Carroll St. Salisburg
31. Date filed (Month, Day, Year)
32. Palistrar's Signature md. 2180 State JUN 2 3 2005 Registrar

		-	For State Registrar	State of M	aryland		artment of I		ind Mental Hy	giene Reg. No (ากร	22692
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9	1+1VA		30. Name and address of person w	ho completed caus	se of death	(Item 23a) (Ty	pe, Print)	2, &	losenos	I, M	021			
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	xamin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Dea	th	4c. County of Dea	ath
	2		SHADY GROVE ADVENT			ROCKVILLE		MONTGOME	
3	ineral		5. Social Security Number 6. Set XXX	7. Age (In yrs.		If Under 1 Year If Under 24 Hr.	(Month, Day	Year) 9. Bir	rthplace (State or Foreign country)
The same	rector		Usual Residence of Decedent	40	Yrs.		JULY 05	, 1964 RH	ODE ISLAND
ryłan	show at at		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation			10d. Inside City Limits
e Ma	III III	cto	MARYLAND PRINCE G	EORGES MIT	CHELLV	ILLE			XX Yes 2 No
th th	or 28	Director	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What C	country?
w th	23a		1261 STOCKPORT COU	RT		20721		UNITED ST	TATES
er de	arma	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
36 safte	0	by Fi	XX Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes AXNo If Yes, Give		1 ☐ Yes XIX No Specify:		Specify: BL	ACK
21215-0036 id within 72 hours at giene.	lural B.E.			Year or Dates:	160 Door	dent's Usual Occupation			
1215-0036 within 72 hours atter death with the Maryland ene.	nd other then "natural", or (tama 23a or 28a-f sho) event, it a Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Business	s/industry
d 212 tiled withi Hygiene.	The M	E C	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)		SHIPPING CLERK		PRIVATE	7
Hygie	other ent, 1		17. Father's Name (First, Middle, Last)				ame (First, Middle, i		2
Maryland d 2 should be tile th and Mental Hy		o Be	TOCE DADOCA			MARIA A	NDDADE		
and Men	marked matic ev	2	JOSE DaROSA 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street and Number or F		r, City or Town, State,	Zip Code)
and 2 and 2 lealth ar	item 27 is marke other traumatic		DAVID ACEVEDO / SO					ILLE, MD 2	
а неа	othe		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of		20c. Location - City of	
	Name and		1 ☐ Burial XXCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		matory or other place)	10.105	4.T. E37.4.3TD.D.T	F A T7 A
Baltimore, bermit. Pages 1 at Department of Hea	important: i eny injury o once.	}	21. Signature of Funeral Seprice-Ligens			ITAN CREMATORY 7 2. Name and Address of Facility		ALEXANDRI	
Balti permit. Departm	e o		. T. Mar	shll	ARSHALL S FUNERA 308 SUITLAND ROA		MARYLAND, LAND, MD 20		
和			23a. Part1 Enter the disease, or comp shock, or heart failure. List only o	ications that caused the deat	th. Do not en	ter the mode of dying, such as cardi	ac or respiratory arr	est.	Approximate Interval Between
Phys	sician		Immediate Cause (Final disease of condition	Cardiac Arrh	_				Onset and Death
	edical		resulting in death)	Due to (or as a conseq					
Exa	miner			_{b.} Cardiomegaly					
D	#	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):				
acute	and I-trans	Examiner	that initiated events resulting in death) Last	c					
760, te be executed	ysicien and ne burial-transit		Todaking in obality East	Due to (or as a conseq	(uence or):				
0	S T	dicai	•	d					
× 6	attending phy I for use as the	Me	IF FEMALE:	20- 14					
Box Bath cert	or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	aldeath 3	Ectopic pregnancy		23d. Date of de Month	elivery Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of c 9☐Unknown	death 5	Other (specify)			5.1,
P.O.	8 S	P.	Part II. Other significant conditions co	atabuting to death but not re-	culting in the	Indorbing course gives in Part 1	23e Did to	bacco use contribute	to the cause of death?
Records,	90	þ	Alcoholism	inibating to death but not res	salung in the t	Riderlying Cause Given in Fair i.	1 🗆 Y		Probably 4 Unknown
oro Des	should should	etec	111CONOTION						
e e c	SCA	Completed					24a. Was a autop:	sy prior to	autopsy findings available completion of cause of
= =	pag	Ö					perfor 1 XYes	med? death? 2 ☐ No 1 ☐ Ye	s 2 No
Vital	After this certiticate has be tuneral director, page 2 s	Be	25. Was case referred to medical examiner?				eath (Check only or	18)	
Of Physi	this c	မ	X ies 5 Ivo		X PVOutpatie			ence 6 □Other (Sp	ecify)
ت ق	ofter t	ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	28d. Describe h	ow injury occurred	
SiO rendi	or: A	cati	2 Accident investigation			M 1 Yes 2 No			
Division f or Attending after death.	n by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, si ify)	reet, factory, office	28f. Location (S City or Tow	itreet and Number or F n, State)	Rural Route Number,
oltal ours at	led i								
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	To the Funaral Director: completely tilled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one) Medical Exam	iner: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the time, date and pla evestigation, in my opinion, death oc	ce, and due to the c curred at the time, c	ause(s) and manner a date and place, and du	as stated. ue to the cause(s)
o the	ompl	Me	29b. Signature and title of certifier	\bigcirc 1		29c. License number	2	29d. Date signed (Mor	nth, Day, Year)
F 3	- 0		MIM	~//V		OCME	Т	ULY 5, 200	5
c 0			30. Name and address of person who d	ompleted rause of death (Ita	m 23a) (Typo	Print)			
CK			S. Name and address of person who d	A A CAUSE OF GRAIN (NO	20a) (1yp8	111 Penn Stre	et Balti	more, Mary	land 21201
ASS.	Sta		31. Date filed (Month, Day, Year)	. Registrar's Sign	ature				
Della.	Registi	ar	JUL 0 7 2005	Bear &	A				

			For State Registrar	State of Mar	yland / D)	epartment of He Certificate of D	ealth and M Death	ental Hygie Rea	2005	22685
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)		-		2. Date of Death Month	Day Yea	
	/Medic Examin	al	Mary 4a. Facility Name (If not institution, give	Jane street and number)	Day	4b. City, Town, or I	Location of Death	June 25, 2	4c. County of De	2:21 A M
	Examili	er	Southern Maryland Ho	· ·		Clinton			Prince Ge	_
	Funeral Director		131-20-2031	ex 7. Age	In yrs. last birth 7 Y	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth Ct. 12, 19	(<u>aar)</u> 9. E	Sirthplace (State or Foreign Country) Canada
	yland sow		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town	or Location	······································			10d. Inside City Limits
	e Man Be-f sh IIII	ctor	Maryland Prince Ge	orge's	Temp1	e Hills				1 ☐ Yes 2 No
	3e or 2	ai Director	10e. Street and Number 3532 28th Parkway			10f. Zip Code 20748		109	g. Citizen of What USA	Country?
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show aumatic event, I'm Mudical Evant at Institute fredition at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ∰Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. White
2	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. [Decedent's Usual Occupat 'Give kind of work done du life. DO NOT use retired)	tion uring most of worki	ng 16	6b. Kind of Busine	ss/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired) rtographer			ederal Gov	ernment
<u>ام</u>	m - 0 2	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma		
ylar	ould be Mental wrked o	ToE	Angus Thomas	14.5			Delina Mi			
Maryland 21215-0036	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (1) Laurie Day Greene/Dau			Mailing Address (Street a Cranberry Drive				
	f Heal f Heal item 2 other	1 3	20a. Method of Disposition			Disposition (Name of crematory or other place			Oc. Location - City	
timore,	Page ment o ant: ff ury or		Burial 2 Cremation 3 Control of C	Removal from State y)		Vet. Cemetery		'2005 Ch	eltenham,	Maryland
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic es		21. Signature of Funeral Service Licen	1590		22. Name and Address	s of Facility George 11 Road Oxo	P. Kalas F n Hill, Ma	uneral Hom ryland 2	e P.A. 0745
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plication that caused to one goes on each line a. Due to (or as a	vasc	ulas ac			it,	Approximate Interval Batween Onset and Death
),	ificate be executed physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence o	pullalion				
68760,	ate be hysicia the bu	edical	(d						
.O. Box 6	The law requires that the death certific the las been signed by the attending page 2 should be detached for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of Month	delivery Day Year
S, D	w requires that to seem signed by should be detail	d by Ph	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying cause give	n in Part I.	23e. Did toba	. /	to the cause of death? Probably 4 Unknown
Vital Record		Completed	() 1					24a. Was an autopsy performe	ed? prior death	autopsy findings available to completion of cause of completion of cause of completion by the completion of cause of completion of cause of completions.
Vita	Physician: this certificated director,	Be	25. Was case referred to medical examiner?	Hospital:		nationt 30 DOA Othe	26. Place of Death			
n of	ing Phys Mer this uneral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	t 2 ER/Out 28b. T Yea <i>r)</i> In	ime of 28c. Injury	at ?	me 5 Residen 28d. Describe how		pecify)
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Injur	y - At home, far (Specify)	M 1 ☐ Y	′es 2 □No	28f. Location (Stre City or Town,		Rural Route Number,
	e Hospital 24 hours a e Funeral l letely filled	Medical C			examination and	death occurred at the time Vor investigation, in my op				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	20		29c. License	number	290	d. Date signed (Mo	onth, Day, Year)
L			000	ell Pose	5	- DI	765	5	6/25	105
0	P (15)		30. Name and address of person who 31. Date filed (Month, Day, Year)	150nMD	ath (Item 23a) (O Secrat	s Rut	Lap CI	inton.	M20735
	Sta Regist		JUN 2 8 200.		J. A	hade				

			State of Maryland / Depar State of Maryland / Depar Registrar	tment of Health and M ficate of Death	lental Hygier	2005 22686	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	
	Physicia /Medic		DAVID MICHAEL DILLMAN		JUNE 2	$\overset{\text{pay}}{2}$, $20\overset{\text{year}}{05}$ 9:44P. M	4
	Examin			b. City, Town, or Location of Death		4c. County of Death	
			PRINCE GEORGES HOSPITAL	CHEVERLY	P	RINCE GEORGES	
	Funeral		1171M 2□ E	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)	n
	Director		195-72-3498 184 2 7 23 Yrs. Usual Residence of Decedent		Aug. 13, 1	981 Maryland	
	show		10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits	3
	Mary I-f sh	ţō	MD Prince George's Bladensbur	g		1 X Yes 2 □ No)
	h the	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?	
	th wit	alD	4915 Newton Street	20710	U.	.S.A.	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in	as Decedent of Hispanic Origin? (Spi es, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	s afte	by Fu	1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 1 No If Yes 2 No If Yes 1 No If Yes 2 No If	Yes 21 No Specify:		Specify:	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be notified at	ed b		nt's Usual Occupation	16h	White Kind of Business/Industry	
5	n "na	Completed	(Specify only highest grade completed) (Give kill	nd of work done during most of work NOT use retired)	ing	Tring of Businessanidustry	
212	d with	mo	Self I	Employed	He	ome Improvement	
9	al Hy	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Sumame)	
<u>ya</u>	Ment Ment arked arked	To I	Barnett S. Dillman	Penny Su	e Dinch		
Maryland	2 short and is m		Harrier Committee Co	Address (Street and Number or Run			
	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene for them "natural", or items 23s or 28s-f show Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. It a Medical Examinatinate in collised at		Barnett S. Dillman, Father 4915 N 20a. Method of Disposition 20b. Place of Disposit	Newton St., Blade			_
آور	ages or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crema	tory or other place)		Location - City or Town, State	
Baltimore,	permit. Pages Department of importent: If II eny injury or c		`4 □Donation S □Other (Specify) Cedar Hill 21. Signature Furieral Service Licensee 22.	L Cemetery 06/29 Name and Address of Facility Gas	72005 Su	itland, Maryland	_
Ba	permit, Pages 'Department of H importent: If Ite eny injury or ot once.		Laborat 1 11 ag/ 47:	39 Baltimore Aver	ue, Hyatt		
п			23a. Part 1. Enter the disease, or complications that aused the death. Do not enter shock or heart failure. List only one cause of each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	
	Physician	11	Immediate Cause (Final disease or condition Guushot W	ound of Tor		Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		L.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	nsit	in	Cause (Disease or injury				
ς,	execu n and ial-tra	Examiner	that initiated events c				
68760,	ficate be executed physician and s the burial-transit	dicai	d				
	ntifica ng ph as th		IF FEMALE:				
Вох	leath certific attending p	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ctopic pregnancy		23d. Date of delivery	
.O.	the at	sici	1 Yes 2 No	Other (specify)		Month Day Year	
Δ.	that the dended by the a	Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	erhing cause gryen in Part I	23e Did tohaco	to use contribute to the cause of death?	
Records,	De de	d by	. a.m. eme erg. mean erg.	origing cadoo given in reacts.	1 ☐ Yes	2 No 3 Probably 4 □Unknown	n
20	w requir been si should	Completed			24a. Was an	24b. Were autopsy findings available	
Re	he lav s has ge 2	ф			autopsy performed	prior to completion of cause of death?	Э
Vital	icien: Th certificate rector, pag	e C	25. Was case referred to medical	26 Place of Deat	1 Yes 2	No 1 TYes 2 No	_
>	Physicien: r this certifica ral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 XER/Outpatient	Other		6 □Other (Specify)	
Jοι	ding Physicien: The n. After this certificate ha funeral director, page		27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how in		
<u>Si</u>	utendir death. ctor: Af y the fur	atic	2 Accident investigation 6 22 105 8:56	OM 1 ☐ Yes 2 X No	Subje	ctshot	
Division	or Attending Ifter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate) 4915 Nowton St.	
Ω	urs af		Street		H 40 115	VILLE HO	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 □ Certifying Physician: To the bast of my knowledge, death of the bast of examination and/or invegence and manner stated.	occurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause red at the time, date :	e(s) and manner as stated. and place, and due to the cause(s)	
	ro the vithin ro the complex	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
			Large Hallow und	OCME	ИIL	E 23, 2005	
(*	R (4)		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) 111 Penn Street		e, Maryland 21201	d
	Sta	ate	31. Date filed (Month, Day, Year)			, IMI JIMIN 21201	
	Registi		JUN 2 8 2005				

DHMH 17 Rev 1/2001

ORIGINAL

			State of Manyland / Den	eartment of Health and Mental Hy	9
			1 _ State		000 = =================================
		,	1. Decedent's Name (First, Middle, Last)	2. Date of De	
	Physici		ELIZABETH VIVIAN DAVIES	Month	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	17, 2005 7:00AM Ac. County of Death
	LXUIIII	ابا	14 GREYSTONE CIRCLE	WALDORF	CHARLES
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		
	Director		187-18-0423 1□ M 2□XF 83 Yrs.	MAR. 4	
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	/anylan	ō	MARYLAND CHARLES WALDOR		1 ☐ Yes 2 🛣 No
	28a-	rect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	aa or	Funeral Director	14 GREYSTONE CIRCLE	20602	U.S.A.
	death ms 2	Jera		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9	after or Ite	E	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₹ No If Yes, Give	17.17	
903	rel',	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: WHITE
21215-0036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23a or 28a-f show in Majical Extrairer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
121	within ene. then	d L	Elementary/Secondary (0-12) College (1-4or 5+)		
	filed Hygie other		17. Father's Name (First, Middle, Last)	EMAKER 18. Mother's Name (First, Middle,	OWN HOME
lan	Mental larked o	To Be	JOHN HENRY LEWIS	HELEN MARIE	UMLAH
Maryland	should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rural Route Number	
	1 and 2 Health a em 27 is		ALICE BAGGETT-DAUGHTER 14	GREYSTONE CIRCLE, WA	LDORF, MD 20602
ore			20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 20b. Place of Disposerery, cre-		20c. Location - City or Town, State
Baltimore,	Pa men ury			AN CREMATORY 6-19-05	ALEXANDRIA, VA
Salt	perr it. Pa Dep rtmen Important: any injury		21. Signature of Funeral Service Licensee M00479	22. Name and Address of Facility	
	<u>0.05</u> = 0.0		Mulul July	RAYMOND FUNERAL SERV	0646
1			shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between
	Prysician	i N	Immediate Cause (Final disease or condition resulting in death)	nown ASCVV	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	1 + 10 - 10 d . 1.	_
	X	in lie	Edgue thally fist conditions, if any, leading to immediate Due to (or as a consequence of):	were weren ty	be I July
✓	uted d ansit	Examiner	Ecque, Itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	V	
ć	e be executed sician and e burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):		
120		cal	d		
89	The law requires that the death certifical tie has been signed by the attending phyage 2 should be detached for use as the	Physician/Medl	IF FEMALE:		
Вох	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery Month Day Year
0.	the a	/sici	1 Yes No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
0	that the de led by the a detached f	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underhing cause given in Part I 23a Did t	obacco use contribute to the cause of death?
Records,	signe d be	d by		1 🗗	
Sor	w requir been si should	ete		24a. Was	
Re	he lav s has ge 2	Completed		autor	
Vital		o Co	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only of	2 No 1 Yes 2 No
>	Physicien: this certific ral director,	OB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	
J of	Pa ta la	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Manner of Death 28a. Date of Injury 28b. Time of Manner of Death 28a.		how injury occurred
jor	Attending ir death. ector: After by the funer	atlo	2 Accident investigation	M 1 Yes 2 No	
Division	or Attendated death Director:	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office 28f. Location (S City or Tov	Street and Number or Rural Route Number, wn, State)
	itel o				
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manager stated.	th occurred at the time, date and place, and due to the evestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	ithin 2 o the	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	ĕ∃€ĕ		ML los Oll vi	D D 2975	C-18-00
	/		30. Name and address of person who completed cause of death (Item 23a) (Type	. Print)	6 10 0 5
	5		Daniel Howell, MD /	nibroche Se. 11)	aldorf, MD
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registr	ar	JUL 1 1 2005 Region 18	books	

			For State Registrar	State of M	laryland	-	artment rtificate			and M	-	-	005	5 2	268	99
	Physicia	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month		v Y	ear	3. Time of	Death
N.	/Medic	al	ETHEL	P.	DAVI	S					JUNE	18	2005	1	1:35	A M
	Examin	er	4a. Facility Name (If not institution, g		7)		4b. City, To	own, or l ISBU		of Death		4c.	County of WICOM			
	Funeral		WICOMICO NURSING 5. Social Security Number 6	. Sex 7. A	ge (In yrs. las	t birthday)	If Under 1	Year	If Under 2		8. Date of Bir	rth			ce (State or	r Foreign
	Director		215-01-0081 Usual Residence of Decedent	1□M 2X F	91	Yrs.	Months	Days	Hours	Min.	(Month, Da FEB • 15	y, Year)	14		YLAND	
	yland Now		10a. State 10b. County		10c. City,	Town or Lo	ocation							100	d. Inside Cit	y Limits
	a-f sh	ctor	MARYLAND WICOM	IICO	S	ALISE	BURY								1X☐ Yes	2 No
	or 28	Directo	10e. Street and Number				10f. Zip C	Code				10g. Cit	izen of Wha	t Countr	y?	
	sath w		MAIN STREE		Survin III C	140.1		2187	<u> </u>	: 0.40	7.7		USA			
0	r Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 ☐ Yes 2X	? ?] No			_	, Mexican	, Puerto	ecify Yes or No Rican, etc.))-	14. Race Black, \	White, et		
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23s or 28s-f show ant, Its Medical Examinar must be notified at	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2X	No 🖸	Specify:				Specify:	WH	ITE	
<u>,</u>	be filed within 72 hd tal Hygiene. d other than "natur event, the Medical	Completed	15. Decedent's (Specify only highest)	Education grade completed)		(Give	dent's Usual kind of work DO NOT use	done du	tion <i>tring m</i> ost	of worki	ing	16b. K	ind of Busin	ess/Indu	stry	
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9	~ - 0 0	BeC	17. Father's Name (First, Middle, La	st)				1	18. Mothe	r's Name	(First, Middle	, Maiden		попъ		
<u>Z</u>		2		ADKINS					M	(INN	E		WILKI	NS		
Maryland 2	0 0 0		19a. Informant's Name/Relationship		1						I Route Number				-5	
	s 1 and f Health tem 27 other to	- 3	FRANK A. DAVIS/ 20a. Method of Disposition			e of Dispo	sition (Name	of of			RIVE, S.		BURY , ocation - Cit			
E	00		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe		9		natory or othe CEMET		1	6/22	/05	T.T	ILLARI) C 1	MADVT /	MID
saitimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lic	censee			2. Name and				703		LUDANI	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	TAKI LE	TIND
ח	205 20		+ sheetle 9	farres							ME, SE		ILLE,	DE.	19975	5
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each	ine.	Do not ent	er the mode (or ayıng,	, such as	cardiac c	r respiratory a	rrest,		i Ir	opproximate nterval Betw Onset and D	veen
	certificate be executed and iding physician and ise as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. ACUT Dua to (or as	s a consequer	ESPIK	ATOR	Υ	FA	116	RE					
ñ	death e atter od for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic preg Other (spec						23d. Date of Month			ear
rds, r	es ti gne be c	by	Part II. Other significant conditions		but not resultii	ng in the ur	nderlying cau	use given	n in Part I.			obacco L Yes 2	se contribu	te to the		eath?
ecord	e law requir has been si je 2 should	Completed	RELIPHERAL	ARTER	IAL	D	ISEAS	F			24a. Was				y findings a	
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VITAI	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor	1000		Check onl		-			
	ding Phye h. After this funeral di	ion: To	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ury ay Year) 28	VOutpation 3b. Time of Injury		c. Injury a Work?	4 V Nur	2	ne 5 Resid 28d. Describe I			Specify)		
UNISION	l or Attending after death. Director: After in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of In	njury - At home	e, farm, str			35 2 1		28f. Location (S	Street an	d Number o	r Rural F	Route Numb	er,
	tel or A s after et Dire ed in by	Cert	4 Homicide Getermine	building, e	tc. (Specify)						City or Tov	wn, State)			
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination	edge, death n and/or inv	n occurred at vestigation, in	the time	, date and nion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and manne place, and	er as state due to th	ed. ne cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	, -			29c. l	License r			_	29d. Dat	e signed (N	fonth, Da	y, Year)	
	\sim		· / Ulakun	will	/	UD		> -	2060	25/3	5	(5/20	110	•	
	0	1	20 11-		d 4b //:	2-1-5							1	10-		
	Ex.		30. Name and address of person wh MAHESHA THIMMA						DR.,	SALI	SBURY,	MD	21804	10-		

		•	For State Registrar		State o	f Marylar	-	artment of H		and Me	_	_	005	22690
			1. Decedent's Name (F	irst, Middle, Las	st)						2. Date of De		Year	3. Time of Death
	Physici: /Medic		Amarech G	ebresel.	assie 🛚	Dibaba					06 -		2005	11:42 a M
	Examin	er	4a. Facility Name (If no					4b. City, Town, or		of Death			County of Deat	
			Washington 5. Social Security Number			pital 7. Age (In yrs.	last hirthday)	Takoma If Under 1 Year	lf Under	24 Hrs.	8. Date of Bir		ontgome	hplace (State or Foreign
	Funeral Director		220-49-577		□M 2⊠F	69 (iii yis.		Months Days	Hours		04-03-	1 936	Co	nplace (State or Foreign ountry) .iopia
	ס		Usual Residence of De	cedent					<u> </u>					
	arylar show	_		b. County			ty, Town or Lo							10d. Inside City Limits 1X Yes 2 □ No
	he M	ecto	Maryland 1	Montgom	ery 		Germant	10f. Zip Code				10- 0''	zen of What Co	
	with Se or	Funeral Director	12861 Clim		u Drive			20874				Ethic		untry
	death ms 23	era	11. Marital Status	DING IV	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	gin? (Spec			4. Race - Ame	
ဖွ	or Ite	교	1 Never Married	2 Married	Armed F 1 ☐ Yes If Yes, G Year or [orces? 211 No		If Yes, specify Cuba 1 ☐ Yes 2 2 No	an, Mexicar Specify:		lican, etc.)		Black, White Specify: B1	
99	uret',	d by	3 Widowed 4		L	ates:								
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then Insturelt, or Items 23e or 28e-f show ant, the Maclical Examinar must be motified at	Completed	(Specify	. Decedent's Econly highest gra			16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation <i>during m</i> osa 1)	t of workin	g	16b. Kir	nd of Business/	Industry
12	iene.	шо	Elementary/Seconda 7th	ary (0-12)	College (1-4or 5+)	Homem		-/			Self.	-Employ	ed
Ď	e filed of he vent,	Be C	17. Father's Name (Fire	st, Middle, Last)			1		18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)	
/lar	uld be Venta vrked	To B	Gebreselas	sie Dib	aba				Aste	de W.	Mavia	ım		
Maryland	2 sho and l	0 8	19a. Informant's Name				19b. Maili	ng Address <i>(Street</i> herrywood	and Numbe	er or Rural	Route Numb	er, City or	Town, State, 2	Zip Code)
	l and lealth im 27 iher tr	3	Beyene Ber 20a, Method of Disposi	.	usin	30h	Gaith	ersbur	Mary	land,	20878		antina Cibura	Towns Shake
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturet; or Items 23e or 28a-1 show amortent: If Item 27 is marked other then." and the notified at any injury or other treumatic event, the Madical Examinating the notified at ance.		1 XBurial 2 □ C	Premation 3 □		State	cemetery, creating Ce	matory or other plac		07 – 03			cation - City or s Ababa	
Ħ	artme artme ortent injury		* 4 □Donation 5 [21. Signature of Funer			l' an	•	2. Name and Addre	i		05			Ethiopia
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П			23a. Part1. Enter the o shock, or heart fa	ailure. List only	plications that one cause on	caused the dea each line.	th. Do not en	ter the mode of dyin	ng, such as	cardiac or	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	3 7	Immediate Cause (Fin disease or condition resulting in death)	na!	a		nonan	1 emb	lism					Gridor and Boarin
	Examiner		,	ſ	Due to	(or as a conse	_) +	4		- 1	-	200000	
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,0	ate be executed hysician and the burial-transit	EX	resulting in death) Las	t	Due to	(of as a consec	querice of):	0		(and hi	ystove	ctours /	n Toophovectory
8760,	icate be executed physician and s the burial-transit	Physician/Medical			d								0.	
9		/Me	IF FEMALE:		23c If yes or	itcome of pregn	ancy						204 Date of dal	
Вох	death of atten	clan	23b. Was decedent pr in the past 12 mg	iths?	1 ☐ Live	birth 2 ☐ Fet	al death 3[Ectopic pregnancy Other (specify)	/			2	23d. Date of del Month	Day Year
0	the d ached	hysi	1 ☐ Yes 2 ☑ N 9 ☐ Unknown	ło	9□ Unki								N/A	
S, D	requires that the death certif een signed by the attending nould be detached for use a	by P	Part II. Other significa	nt conditions	contributing to	death but not re	sulting in the u	inderlying cause giv	en in Part I		23e. Did	tobacco u	se contribute to	the cause of death?
ıd	w require been sig should b										10	Yes 2	Mo 3□Pr	robably 4 Unknown
ecc	law as b 2 st	plet									24a. Was			utopsy findings available completion of cause of
of Vital Record	The ate h page	Completed									perf	ormed? 2 No	death? 1 ☐ Yes	
Vita	Physicien: The this certificate ral director, page	Be	25. Was case referred examiner?	I to medical	Hospitals	/		0#		e of Death	(Check only	one)		
of	S S	2	1 ☐ Yes 2 ☐ No 27. Manner → Death		Hospital:		28b. Time of		4 🗆 140		ne 5 🗌 Res 28d. Describe		Other (Spe	cify)
	ding h. After funer	ertification;		5 Pending investigatio		nth, Day Year)	Injury	Wor	rk? Yes 2. □		ed. Describe	now injur	y occurred	
Division	or Attending after death. Director: After in by the fune	ifica	3 🗌 Suicide	6 Could not b		e of Injury - At I	nome, farm, st	reet, factory, office			28f. Location	(Street an	d Number or Ri	ural Route Number,
á	i Sign	Cert	4 Homicide	/	buile	ling, etc. (Spec	ity)				City or 10	own, State,)	
	Hos 24 h Fur stely	edical (29a. Certifier 1 (Check only 2 one)	Certifying Pi	miner: On the	e best of my kn basis of examin nner stated.	owledge, dea ation and/or in	th occurred at the timestigation, in my o	me, date ar opinion, dea	nd place, a ath occurre	and due to the	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and titl	e of certifier		1 /		29c. Licens					e signed (Mont	•
			.	Dur.	Suit	in		D	006	1707		j.	INE Z	3,2005
· N	(2)		30. Name and address	s of person who	completed cau	ise of death (Ite	m 23a) (Type	, Print)	_					3.2005
个				610 Ca	molli	Ave,	Suite	270 ,	Takei	na fe	AVC.	MD	2091	12
	Sta Regist	ate rar	31. Date filed (Month,			Registrar's Sign	nature							
DH	MH 17 Rev 1/2		JUN	& 1 £UU	13 /00	an A	A	ME)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 20a, b, c per fh 3848 10-17-05 vt. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended item #20c per fh/wichartificate of Death 6-24-05/dls Reg. 1005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 11: 15AM -99975 al 05 /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Examiner 5. Sex

1. Age (In yrs. last birthday)

1 M 20 F

Yrs. rchorage 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days 229-82-6234 Usual Residence of Decedent/ Director the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene.
ant: If item 27 le marked other than "natural", or Itams 23e or 28a-f shov ury or other treumatic event, Itts Medical Exandract must be rediffical at MD 1 Yes 2 No Directo Jalistal Conc 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21804 -S. A Hive 008 Hds Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, elc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: BIAC Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hutel- Holiday Inn 12th Gral LUYS Keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E/113 JUL SON elyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1008 ademsayer Date 200 Cotton - City or Town, Slate Delmar, De Urlette Drugton/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any Injury or once. Delmarva 7-12-05 Cremetory * 4 □ Donation 5 □ Other (Specify) Salisbury, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ic Smith Funeral biry, nd 21501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HIV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 🗷 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 213 No 1 Yes Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NIM 047094 6/21/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 DIVISION ST SEB SOLINDWY MD 21804 Vel NATESAW 1415 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State JUN 2 4 2005 Registrar

1 - For State Registrer State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 5 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** BETTE B. FLEMING 18, 2005 JUNE 10:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 345 PLEASANTON RD. WESTMINSTER CARROLL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 28 □ F Director 216-22-8412 78 15/1927 MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "netural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 ☐ No MD CARROLL WESTMINSTER Direct 10e. Street and Number 10f. Zin Code 10q. Citizen of What Country? 345 PLEASANTON RD. 21157 Funeral USA filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) TELLER BANK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic ever 2008. HOWARD LEE BAIR, SR. MAMIE BARNES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HERMAN W. FLEMING -HUSBAND 345 PLEASANTON RD., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation Other (Specify) EVERGREEN MEM.GARDENS 6/21/05 FINKSBURG, MD. 21. Signature of 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Fine! **Physician** Pancreatic Matastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Page 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Causa (Discass or inju-that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown cete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Noze Knows 1 Yes 2 No 3 Probably 4 nknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1□ Yes 212 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Haturai 5 Pending To the Hospital or Attandii within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Md. # D15552 6/20/03 WIL M.D. 0 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 South Cuter Street Wootmister, MD21167
32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JUN 22** 2005 Registra

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			1 - For State Registrar	State of M	aryland		artment tificate					_	005	2269	3
	Physici /Medio		Decedent's Name (First, Middle, Las	Frank	Cliff	ord					2. Date of De Month	OB Day	2 ∞′	5 0609	eath A.M
	Examir	er	4a. Facility Name (If not institution, give Washington Count	y Hospita	1		На	gers	town			V	County of De Vashin	gton	
	Funeral Director		5. Social Security Number 6. Sec. 208–28–6512	X 7. Ag	67	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da June 2	1938	9. B	irthplace (State or F Country) enna •	Foreign
	Maryland a-f show	tor	10a. State 10b. County Penna. Frankli	.n		Town or Lo				-				10d. Inside City	
	th with the 23a or 28a	al Director	10e. Street and Number 5762 Montgomery	Church Ro	1.		10f. Zip	Code 7225				-	en of What	Country?	
036	n 72 hours after deeth with the Maryland "natural; or items 23e or 28e-f show calcal Exaciner cast be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	•		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, W	nerican Indian, nite, etc. White	
21215-0036	within ane. then *	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give life.	dent's Usua kind of wor DO NOT us Machi	k done d e retired,	urina mos	t of worki	ng		d of Busines	ŕ	
Maryland 2	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) William S	Foster							(First, Middle		Sumame)		
, Mar	ges 1 and 2 should t of Health and Mer if item 27 is marke or other traumatic	1 9	19a. Informant's Name/Relationship (7 Barbara A. Foste			5762	Mont	gome			Route Numb			, Zip Code) , Pa. 172	:25
	Pages 1 nent of He ant: if iter ury or oth		20a. Method of Disposition 1 🕱 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify		cen	netery, crer	sition (Nam natory or of 11 Ce	her place	· 1	7/7/	05			or Town, State	
Balt	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licen.	see 	-J	_ Z	Name and immer	man	And S	Son F	uneral Greenc	Home astle	Inc.	17225	
*	cate be executed by Sician and Examiner the burial-transit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as d	a conseque	no of): / ho								Approximate Interval Betwee Onset and De	en ath
.O. Box 6	The law requires that the death certificate be execute has been signed by the attending physician and rage 2 should be detached for use as the burial-transate.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	eath 3	Ectopic pro					2	3d. Date of o	lelivery Day Yea	ar
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions or	ontributing to death b	out not result	ing in the u	nderlying ca	ause give	n in Part I	•				to the cause of dea	
of Vital Records,		Completed									24a. Was auto perfo 1 \(\text{Yes}		24b. Were prior to death'		ailable ise of
	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	ition; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	IV 2	R/Outpatier 8b. Time of Injury		Bc. Injury Wark	^{IC.} *4 □ Nu	ursing Hor	Check onl one 5 ☐ Resi	idence 6	Other (Sp	pecify)	
Division	is Diff.	Certification;	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hom tc. (Specify)	e, farm, str	eet, factory	, office		-	28f. Location (City or To	(Street and wn, State)	Number or	Rural Route Numbe	er,
	To the Hospitei or within 24 hours afte To the Funeral Dire completely filled in h	edical	29a. Certifier (Check only one) Check only one 2 Medicel Exemption	ysician: To the best liner: On the basis of and manner st	of examinatio	edge, deat n and/or in	h occurred vestigation,	at the tim in my op	e, date an inion, dea	nd place, a	and due to the ed at the time,	cause(s) a	and manner place, and d	as stated. ue to the cause(s)	
)	To t withi To t	N	29b. Signature and title of certifier Muchuel	g. mi	him	M		. License	number	67			signed (Mo	nth, Day, Year)	
	12		30. Name and address of person who	mpleted cause of	death (Item 2	(Туре,	Print) Medi	cel	Car	cur	Hes	erst	٧٠٠	mo 20	742
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 1 2005	22. Regist	rar's Signatu	re Jose	le le								

			1 - For State Registrar			Marylan		artment of F			R	leg. N2	005	226	94
П	Physici	an	1. Decedent's Name (First								2. Date of Dea Month	Day	Year	3. Time of	
	/Medic		Peter Terry 4a. Facility Name (If not it			per)		4b. City, Town, or	r Location of	of Death	July	4c, Co	2005 ounty of Death	2:50	P ^M
	E X d I I I I	CI	Frederick I					Frederi					rederi		
(43	Funeral		5. Social Security Number	6. Se		. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	1		place (State or	Foreign
	Director		579-28-5550 Usual Residence of Dece		IM 20 F	8	32 Yrs.				November	8, 192	22 Wasl	nington,	D.C.
	ow or			. County		10c. Cit	y, Town or Lo	cation						10d. Inside Cit	y Lîmits
	• Man	ctor	Maryland 1	frederi	:k		Jeffers	son						1 🗌 Yes	2 X No
	or 28	Dire	10e. Street and Number					10f. Zip Code				10g. Citize	n of What Cou	ntry?	
	s 23a	rail	4249 Horine					217					U.S.A.		
	Items Items	by Funeral Director	11. Marital Status 1 ☐ Never Married 2		12. Was Deced Armed Forc 1 Tyes 2	es?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Ori In, Mexican	gin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
980	urs af	by	3 XWidowed 4 □ 0		If Yes, Give Year or Dat		1	1□Yes 2▼No	Specify:			S	pecify: Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene than "natural, or items 23a or 28e-f show the Medical Exertinat Le ricitified at	Completed		Decedent's Edu			(Give	lent's Usual Occupa	durino mos	t of work	ina	16b. Kind	of Business/Ir	idustry	
7	vithin ne. han	mpi	Elementary/Secondary		College (1-4	lor 5+)	life. L	DO NOT use retired	1)		9				
Р	filed v Hygie Ither t	Co	17. Father's Name (First,				1	Lithograp		er's Name	e (First, Middle,	Maiden Su	Prin	ting	
Maryland	lid be lental kad o	To Be	Ligor Grego	ory							a Vasil				
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event, the Medical Exercitivation at the Inclifted at ODGs.		19a. Informant's Name/P	Relationship (Ty	pe, Print)		19b. Mailin	ng Address (Street				r, City or T	own, State, Zij	Code)	
Σ,	and 2 ealth n 27 I		Jeanette L.		aughter		4249	Horine R	oad,			Mary1	and, 2	1755	
altimore,	ges 1 t of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre		emoval from St	ale		sition (Name of natory or other place				20c. Loca	tion - City or To	own, State	
III III	it. Pa rtmen rtent: njury		' 4 ☐ Donation 5 ☐ 0			Се		11 Cemete		-	, 2005	Sui	tland,	Mary1a	nd
Ba	perm Depa Impo any i		P. R.	an M	1º mil	lian	Ke	. Name and Address eney and Ba	sford	P.A.		ome F		Church S , MD, 21	
	Physician		23a. Part1. Enter the dis shock, or heart fails Immediate Cause (Final disease or condition resulting in death)	ease, or compliance. List only or	ie cause on ead	used the deat th line. 11 Hema		er the mode of dyin	g, such as	cardiac o	or respiratory arr	est,		Approximate Interval Betw Onset and D 18 hrs	een eath
	/Medical Examiner		resulting in death)			r as a conseq	uence of):								
ļ,		Je.	Sequentially list condition if any, leading to immedia	ns, ate	Due to (or	as a conseq	uence of):								
V	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Lisease or injury that initiated events	1									- 10		
ő,	e exe cian a urial-t	I Ex	resulting in death) Last	- 1	Due to (or	as a conseq	uence of):								
8760,	rcate be ex physician s the buria	dical			l										
9 X C	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ian/Me	IF FEMALE: 23b. Was decedent preg	nant 2	3c. If yes, outco	me of pregna	ancy					230	I. Date of deliv	an/	
. Box	death e atter	iciar	in the past 12 month		4□Pregnar	h 2∏Feta nt at time of d		Ectopic pregnancy Other (specify)				250	Month	•	ear
P.O.	that the de ed by the a detached	Physici	9 🗆 Unknown		9∐ Unknow										
	ires tha	þ	Part II. Other significant Caumadin	conditions cor	tributing to dea	th but not res	ulting in the ur	nderlying cause give	en in Part I.			_		he cause of de	
0.00	w requir been si should	eted	Cadmadin								1 L Y	es 2 (X)		oably 4 ⊟Ur	
Rec	The law ate has l page 2 s	Completed									24a. Was a autops	n 2 sy med?	4b. Were auto prior to co death?	psy findings a mpletion of ca	vailable use of
ta	ician: Th certificate ector, pag	e Co	25. Was case referred to	medical					OC Disease	of Dooth	1 ☐ Yes	2X No	1 ☐ Yes	2 No	
<u> </u>	d is	OB	examiner? 1XYes 2□No	_	ospital:	patient 2	ER/Outpatien	t 3 DOA Othe			n <i>(Check only on</i> me 5□Reside		Other (Specif	·	
0 _	ding Ph th. : After th funeral	n: T	27. Manner of Death 1 Natural 5	Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injury Work	at		28d. Describe ho			,,	
Sio	itandii death. tor: A the fu	catic	2 XAccident	investigation Could not be	July 2		9:00	A ^M 1 (1)	Yes 2 X	-		.l at			
Division of Vital Records,		Certification:	4 Homicide	determined	28e. Place of building	f Injury - At ho , etc. <i>(Specif</i>	y) _	eet, factory, office			28f. Location (St City or Town	n, State)	4249 Hor	ine Road	
	spital ours naral filled		29a. Certifier 1 (Certifying Phys	sician: To the b	est of my kno	hom wledge, death	occurred at the firm	ne, date and	d place,	and due to the ca	ause(s) an	d manner as s	n, MD, 2 tated.	1755
	To the Hos within 24 h To the Fur completely	Medicai	Unej	/	and manne	is of examina r stated.	tion and/or inv	restigation, in my or		th occurr					
1	To Vit		29b. Signature and title	T Certifier	11)		11	29c. License			2	9d. Date s	igned (Month,	Day, Year)	
7	1		30. Name and address of	person who co	mpleted cause	of death (Item	23a) (Type !	D371	.97			July	6, 20	05	
	4		Alan Rohrer		•		, , .	•	7. 7+1	St	. Frada	rick	MD. 2	1701	
	Sta		31. Date filed (Month, Da	y, Year)	32. Re	jistrar's Signa	ture	× - c -			, IICUC	- + CN	1111/		
	Registr	ar	JU	IL 1 1 21	005	alue.	B A	08482							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item #5 per fn/wichd/6-24-05/dls 1- State Amended item #5 per in/wichd/b-24-us/qus
Registrar/Amend item #28c per dr/wichd/certificate of Death6-23-05/dlsReg. No 105 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ROSS WILKINSON GRANT. /Medical -111 Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner alisbury eninsula Kegunal enter Monuco If Under 1 Year | If Under 24 Ars. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 MM 2 □ F Director 219-48-8109 Yrs. $\tilde{2}\dot{2}$. 59 April Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Mudical Exertimer must be notified at Director 1 TXYes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 717 Jefferson Street 21804 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Draw Machine Operator E. I. Dupont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Ross Wilkinson Grant, Jr. Barbara Rector ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Toni_N. Grant, wife 717 Jefferson Street - Salisbury, MD 21804 item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō Department of Important: If it any Injury or o ocuce. 1 ABurial 2 Cremation 3 Removal from State ^ 4 □ Donation 5 □ Other (Specify) St. John's Cemetery 06/25/2005 Princess Anne, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service License e JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NON disease or condition resulting in death) Small Cell m onthis /Medical Due to (or as a consequence of) Examiner Pulmonany
Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner cause. Enter underlying Cause (Disease or injury use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Lireus 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2HNo 1 🗆 Yes 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 ☐ No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: A investigation 1 ☐ Yes - 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funerel Director filled in by Ś 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20041211 1. alle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Month, Day Naz 3 2005

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Salisbury MD 21801

	Please Type or Print in Type of Print in State of Mary & State of Mary & Registrar	Certificate of Death	Reg. No 2005 22696
Physician	Decedent's Name (First, Middle, Last) The state of		2. Date of Death Month Day Year 3. Time of Death
/Medical Examiner	Eric Emmett Graham 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 2 2005 1:12 P M
Cxammer	1500 Patuxent Manor Road	Davidsonville	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In year 123-27-0984 145 M 2 F 23	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 23,1981 9. Birthplace (State or Foreign Country) Maryland
D	Usual Residence of Decedent	City, Town or Location	10d. Inside City Limits
Maryli P-f sho		Upper Marlboro	1 ŽÍ Yes 2 ☐ No
with the Mar	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
offer death virteme 23st	308 King James Ct. 11. Marital Status 12. Was Decedent Ever in		USA ecify Yes or No- 14. Race - American Indian,
Dy by	1 M Never Married 2 Married 1 M Never Married 7 Married Forces? 1 M Yes 2 M No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒No Specify:	Black, White, etc. Specify: White
in 72 h	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry
d 21215-0 filed within 72 ho Hygiene. other then 'naturn ent, ire Medical	Elementary/Secondary (0-12) College (1-4or 5+)	Journeyman Steamfitter	Pipe fitting
	17. Father's Name (First, Middle, Last) Richard R. Graham	18. Mother's Name	e (First, Middle, Maiden Sumame) F. Davi
laryland	19a. Informant's Name/Relationship (Type, Print)	THE SAME AND ADDRESS OF THE PARTY OF THE PAR	al Route Number, City or Town, State, Zip Code)
	Richard R. Graham / father 20a. Method of Disposition		per Marlboro, MD. 20774 20c. Location - City or Town, State
Pages nent of int: If it	1 XBurial 2 Cremation 3 Removal from State	cemetery, crematory or other place)	5/2005 Davidsonville, MD.
Baltimore, permit. Pages 1 ar popartment of Hea important: If item any injury or othe	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bea	all Funeral Home
48240	23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	6512 NW Crain Hwy.	Bowie, MD. 20715 or respiratory arrest, Approximate Interval Between
760, Wedical Examiner Sician and Burial-transit Cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cocaine Into Due to (or as a cons Due to	equence of):	Drowning Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physiclan/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time or go ☐ Unknown	stal déath 3 Dectopic pregnancy 1 death 5 Other (specify)	23d. Date of delivery Month Day Year
cords, F w requires tha been signed should be det	Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy fundings available prior to completion of cause of death? 19 Yes 2 No 19 Yes 2 No
of Vita hysician his certifi Il director	25. Was case referred to medical examiner? 1 12Yes 2 □ No Hospital: 1 □ Inpatient 2		n (Check only one) me 5□ Residence 6∑Other (Specify) Scene
Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification; To Be C	27. Manner of Death 1 Natural 5 Pending investigation investigation 2 Accident investigation 7/2/05	28b Time of P 28c Injury at Work? 12:56 P 1 Yes 2 XNo	28d. Describe how injury occurred Found in shower with water running
Divi	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	home, farm, street, factory, office cify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1500 Patuxent Man Rd. Davidsonville, MD
the Hospitel thin 24 hours a the Funeral I mpletely filled	29a. Certifier 1 ☐ Certifying Physician: To the best of my k	nowledge, death occurred at the time, date and place :	
	29b. Signature and title of certifier	29c. License number OCME	29d. Date signed (Month, Day, Year)
To the I within 2 To the I complete	30, Name and address of person who completed cause of death (It YAMA MTO A KOREU		July 3 2005

ORIGINAL

11:35 A.m.

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HARRIS, GEORGI

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Mary Kendall Hendricks June 22, 7:10 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St. Months | Days | Hours | Min. | April 1 29, 1926 | Indiana 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □ X F 311-22-9806 79 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 1∩a State 10h County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. It is marked other than "natural; or items 23a or 28a-f ehow ury or other treumatic event, Ite Madical Examinate count for notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 16517 Copperstrip Lane USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Kendall Maria Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health as Importent: If Item 27 is any injury or other treu Leon R. Hendricks/ Husband 16517 Copperstrip Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 25, June 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 □Other (Specify) Entombment Gate of Heaven Cemetery 2005 Silver Spring, Maryland 21. Signature of Puneral Service Licenses Francis Adress Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Cuchen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Truncitional cell Carcinoma Comentas /Medical Due to (or as a consequence of): Examiner Cord Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ompressio Examiner or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? 2 **N**o 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 27: Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 060335 June 23,2005 10 Paul Bannen, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Ur. -Registrar's Signature Prince 1811 Olney 20832 31. Date filed (Month, Day, Year) State JUN 27 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar

State of Maryland / Department of Health and Menta! Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** George Benjamin Hatton 10:50P M 2005 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Min 1XM 2□F Hours 83 Director 578-18-9293 August 5, 1921 Wash, DC. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d Inside City Limits rei', or items 23e or 28a-f shov Examiner must be natified at Maryland Prince George Fort Washington Completed by Funeral Director 1X Yes 2 □No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2612 Kingsway Road 20744 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturelf, or item injury or other treumatic even." 1⊠Yes 2□No 1942 If Yes, Give Year or Dates: 1943 1 Never Married 2 N Married 1 ☐ Yes 2 ₺ No **Black** Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Hatton Rosa Brown ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Hatton/Spouse 2612 Kingsway Rd; Ft. washington, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial June 30, 2005 Suitland, MD. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Funeral San 22. Name and Address of Facility 23a. Part1. Enter the disease, of complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pursenthe Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be exacuted that initiated events use as the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 TNo 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARtenosclesone heurs disease 1 Yes 2 No 3 Probably 4 Unknown Alzhermens 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Serume durander 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After s after decay and property and the further further for the further further for the further further further for the further fur 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely fillad in by 4 Momicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 00335 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) Livingsfor Rd # 203. VARNER DELIDRA CI 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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cos			<u>Per FH PGC 6-28-</u> 1. Decedent's Name (<i>First, Middle, La</i> s					2. Date of Deet	h		3. Time of Death
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aryle			19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailing Address (5	treet and Number or Ru	ral Route Number,	City or Town, S	State, Zip	Code)
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ore es 1	0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Place cemet	of Disposition (Name ery, crematory or other	of or place)	Date 2	20c. Location - (City or To	wn, State
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			State of Maryland / Department of Health and Monthstern State of Death 1- State Registrar Certificate of Death	lental Hygie	•	22702
	Physici /Medic		1. Decedent's Name (First, Middle, Last) DAVID CHARLES HAYDEN	2. Date of Death Month June	Day Year 2005	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number) ST. MARY'S HOSPITAL 5. Social Security Number 1 Name of the street and number of	8. Date of Birth (Month, Day,) SEPT - 12	(ear) 9. Birth	ARY'S Iplace (State or Foreign Intry)
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any nigry or other traumatic svant, the Marical Examination at the notified at once.	y Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND ST. MARY'S CHARLOTTE HALL 10e. Street and Number 2966 CHARLOTTE HALL RD. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Married 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Specific Specif	109	g. Citizen of What Cou U . S . A . 14. Race - Amer Black, White Specify: 1111	10d. Inside City Limits 1 □ Yes 2 ☑ No untry?
land 21215-0036	ld be filed within 72 hours ental Hygiene. ked other than "natural", ic svant, tre Modical Ex-	To Be Completed by	3 □ Widowed 4 □ Divorced Year or Dates: USAF 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 1 2 17. Father's Name (First, Middle, Last) FERDINAND CHARLES HAYDEN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOREIGN SERVICE SPE	CIALIST o (First, Middle, Ma	WH Sb. Kind of Business/li U - S - G STATE aiden Sumame)	ITE ndustry OVERNMENT DEPARTMENT
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Print) JANICE ROHME-SISTER 10a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 10b. Mailing Address (Street and Number or Rural 19b. Mailing Address (Street and Num	E, LA PI Date 20	City or Town, State, Zi ATA, MARY Dc. Location - City or T WALDORF,	LAND 2064 Town, State
760,	Physician /Medical Examiner	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause the death. Do not enter the mode of dying, such as cardiac or each line. Due to (or as a consequence of):	LAND 2 or respiratory arr	7	Approximate Interval Between Onset and Death
.O. Box 68	death certific e attending pi d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 9 O		23d. Date of deliv	very Day Year
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	5+1 Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type Int) Michael Certa Mo St. Mary Strospikal 31. Date filod (Month, Day, Year) JUL 11 2005 JUL 12005	527 L	roparellow	un, MD

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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other treumatic event, It e Medical Examinar must be nutified at once.		21. Signature of Funeral Service Lic	censee	- Onto	1211 OC	Name and Address			ale D	Λ	, italy	Land	
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	/Medical Examiner		resulting in death)		as a consequ			A - 10) -1 -0 -5-					
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x	petr Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				MINTER	Pu	Lun) A	A MELA	18 BAS	SE	1 YEAR	1
o,	exection and rial-tra	Еха	that initiated events resulting in death) Last				MUTWE			~				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	dlcai		d. DUA	BETES	s hr	els rus	5					1 467	ル
9	ntifica ing ph e as th	Med	IF FEMALE:										<u> </u>	
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal	death 3[Ectopic pregnancy				23d.	. Date of deli Month	,	Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐ Unknowr	t at time of de n	ath 5L	Other (specify)						,	
Ω.	res that the de igned by the a be detached t	/ Ph	Part II. Other significent conditions	s contributing to deat	h but not resu	ulting in the u	nderlying cause give	en in Part I	1.	23e. Did to	bacco use	contribute to	the cause of c	death?
ds	luires sign lid be	d by								1 □ Y	es 2 🗆 N	lo 3 DIPTO	bably 4 🗆	Unknown
Records,	w requir	Completed								24a. Was a	an 2	4b. Were au	topsy findings ompletion of c	available
Re	The lay	mo								autops perfor	sy med? 2 ☑ No	death?	ompletion of c	ause of
Ita		BeC	25. Was case referred to medical examiner?	5.50				26. Place	e of Death (Check only or				
Ž	hysic his ce i dire	Jo.	1 Yes 2 No	Hospital: 1 1 Inpa	atient 2 🗆	ER/Outpatier	it 3 DOA Othe	er: 4 □ Nu	ursing Home	e 5 🗆 Resid	ence 6 🗆	Other (Spec	ify)	
п	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	Worl	k?		ld. Describe h	ow injury oc	ccurred		
Sic	ottend death ctor: / the f	cat	2 Accident investigat 3 Suicide 6 Could no	t be 280 Place of	Injune - At ho	mo farm et	M 1 □ 1	Yes 2		f. Location (S	treet and N	umber or Ru	ral Route Num	her
Division of Vital	lor A after Direction by	Certification:	4 Homicide determin	ed building,	etc. (Specify	')	cot, lactory, office			City or Tow				50.1
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeref Director: After this certifical completely filled in by the funeral director.			Physician: To the be										
	n 24 I n 24 I he Fu	edical	(Check only 2 Medical Ex	taminer: On the basis and manner	s of examinat stated.	ion and/or in	vestigation, in my o	pinion, dea	ath occurred	I at the time, d	late and pla	ice, and due	to the cause(s	;)
	To t To tl	Ž	29b. Signature and title of certifier				29c. License	e number	, .			igned (Month	_	
			- grilinale	mon	6,		Doo	74	6 3		7-	6-0	7	
	441		30. Name and address of person wi					. Dat		MD 010	0.1			
	Sta	tó	Rolando A. Naje 31. Date filed (Month, Day, Year)	/i 32. Regi	istrar's Signal	ture/	aı Street	, Elk	cton,	MD 219	21			
	Registr		JUL 1 1 2005	Blown	istrar's Signar	Sparke								

			1 - For State Registrar	State	of Maryla		artment rtificate			ind M		giene Reg. N2	005	. 2	2705	
	Physici		Decedent's Name (First, Middle, LUCY MAE HAUSER	,							2. Date of De. Month JULY 2)5 Yea	r	3. Time of Death 12:15 PA	vI
ı	/Medio Examin		4a. Facility Name (If not institution, 343 EARL HAUSER	give street and n	umber)		4b. City, To		ocation o	f Death		4c. C	ounty of De			
	uneral irector		5. Social Security Number 213-82-9945 Usual Residence of Decedent	6.Sex 1 □ M 2 🛣 F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt Month Da MAY 9,	^{v.} 1920	9. E	linthplac Country, KY	e (State or Foreig	חו
Maryland	e-f show	ctor	10a. State 10b. County MD GARRE	тт		ity, Town or Lo	cation						ħ.	10d.	Inside City Limits	
with the	le or 28	Director	10e. Street and Number 343 EARL HAUSER	ROAD			10f. Zip C	550				10g. Citize	n of What	Country	?	
17215-0036 within 72 hours after death with the Maryland ene.	rel', or Items 23e or 28e-f show Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was De Armed F	2.1 No Sive			nt of Hisp y Cuban,	oanic Orig Mexican Specify:	in? (Spe , Puerto I	ocify Yes or No- Rican, etc.)	. 14	. Race - Ar Black, Wi			
C 27275-0- filed within 72 ho Hygiene.	r then "natu the Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	life. I	lent's Usual kind of work OO NOT use IOMEMA	retired)	on ring most	of workii	ng		of Busines N HOMI		try	
<u>a</u> 8 <u>a</u>	9 A	o Be (17. Father's Name (First, Middle, L ARLIE WALTER ME								<i>(First, Middl</i> e, LVIRA B		umame)			
	27 ls	_	19a. Informant's Name/Relationsh NELL HAUSER - D			19b. Mailir	_				I Route Numbe WV 267		Town, State	, Zip Co	ode)	
ore of E	ent: If item 2 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp		n State	Place of Dispo cemetery, cren MEGA CR	natory or oth	er place)	7	D/6/0	ate		ation - City o			
Dall permit. Departn	Importent: any injury o once.		21. Signatu sof uneral Service I	Lux Lux	≠ _{MOC}		Name and				P.O. - OAKLA			550		
	sician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on	caused the dea each line. FERIOSC									Int Or	pproximate terval Between nset and Death EARS	
	edical miner			Due to	(or as a conse	quence of):										
8 / 5U, cate be executed	nysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse											
Geath certific	attending pł for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live	utcome of pregr birth 2 Fet gnant at time of nown	al death 3 □	Ectopic preg					23	d. Date of d Month	l elivery Day	y Year	
ecords, P.O.	been signed by the should be detached	by	Part II. Other significant condition	s contributing to	death but not re	sulting in the ur	nderlying cau	se given	in Part I.						ause of death? / 4 ∐Unknown	1
ਜੂ ਵ ਭੂ	ite has page 2	Completed									24a. Was a autop perfor		24b. Were a prior to death?	comple	findings available etion of cause of	,
OT VICAL Physicien: T	s certific director,	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2] ER/Outpatien	t 3□ DOA				Check onloi ne 5⊠Resid		Other (So	ecify)		
JIVISION OF or Attending Phy tter death.	rr: After this certifica	ertification; T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigs	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time of Injury		: Injury a Work?	t s 2 🗆 N	2	8d. Describe h			cony		
DIVIS el or Atte s after de	at Director: ad in by the	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	208. Plac	e of Injury - At I ding, etc. (Spec	nome, farm, stre ify)	eet, factory, c	office		2	8f. Location (S City or Tow	treet and I n, State)	Number or F	Rural Ro	oute Number,	
DIVISION To the Hospitel or Attender within 24 hours after death	To the Funerel Dir completely filled in	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the xaminer: On the and ma	e best of my kn basis of examin nner stated.	owledge, death ation and/or inv	occurred at restigation, in	the time, my opin	date and ion, death	place, a	nd due to the d d at the time, d	ause(s) ar late and pi	nd manner a ace, and du	s stated	d. cause(s)	_
To th within	To th	Me	29b. Signature and title of certifier		7 -			icense n			i		5, 20		Year)	
4	4		30. Name and address of person w		ise of death (Ite						OAKLAND					
	Sta Registr		31. Date filed (Month, Day, Year) JUL - 5	32.	Registrar's Sign	ature	beek)		* +-			,				

DHMH 17 Rev 1/2001

State

Registrar

TEX

32. Redistrar's Signature

2005 8

			For State Registrar		Sta	te of M	Marylaı	nd / Dep <i>Ce</i>	artmen				lental H		e SUL	15	22707
	Physici	an	Decedent's Nam ROBERT	ne (First, Middle EARL HE									2. Date of I Month	Death D	ay	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (ınd numbe	or)		4b. City,	Town, or	Location of	of Death	JUNE		005 c. County	of Death	8:01P M
	ZXumi		Calvert	County	Memori	al H	osnit.	a1	Prin	nce I	Frede	rick			Ca]	vert	
	Funeral		Calvert 5. Social Security I		6. Sex 1 TM 2	7. /		. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of E (Month, I	Birth Day, Yea	r)	9. Birthp	lace (State or Foreign try)
	Director		218-58-18 Usual Residence		- ZX		56	115.					June 3	194	9	Wash	ington, DC
	arylan show	_	10a. State	10b. County				ity, Town or L								1	Od. Inside City Limits
	the Mark	ecto	Maryland 10e. Street and Nu	Calve	ert		Po	rt Rep		0.4.				10.0	No		1 ☐ Yes 2 No
	3e or	Funeral Director	3160 No		110				10f. Zip	206:	30			10g. C	itizen of W	vnat Cour JSA	iry?
	death	nera	11. Marital Status	. CII AVCI	12. Wa	s Deceder	nt Ever in t	J.S. 13.	Was Deced			gin? (Spe	cify Yes or t	No-	14. Race	- Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importent: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic avent, if a Medical Enature must be rudified at Once.	by Fu	1 ☐ Never Mar 3 ☐ Widowed	ried 2 Marn	ed 15	ned Force Yes 2[es. Give ar or Dates] No		1 ☐ Yes :		Specify:		нісал, өтс.)			k, White. : Whi	
9	2 hour	ted t		15. Decedent	's Education			16a. Dece	dent's Usua	al Occupa	ation			16b.	Kind of Bu	siness/Inc	dustry
215	thin 7. e. an "n	Completed	(Spe Elementary/Sec	cify only highes ondary (0-12)		<i>leted)</i> llege (1-40	or 5+)	1	kind of wor DO NOT us	rk done d se retired	during mos ()	t of workii	ng				,
2	filed wi Hygien other th	Con	10	(Fi 4 induly	(Pa	inter		40.04.45		(E)		onstr	-	on
Maryland 21215-0036	ld be fi ental F ked ot ic aver	To Be	17. Father's Name Earl F	. Heath	Last)								(First, Midd nons H			Θ)	
ary	2 should and Men Is marke aumatic	-	19a. Informant's N	lame/Relationsh	nip <i>(Type, Pri</i>	nt)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Num	ber, City	or Town,	State, Zip	Code)
	and 2 eaith in 27 I		Tracy L		(daugl	nter)							E, MD	2060	2		
altimore,	Pages 1 nent of H ent: If iter ary or oth			☐ Cremation		I from Stat	te 20b.	Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther plac	e)	D	ate	20c. l	Location -	City or To	wn, State
Ħ	permit. Page Department of Importent; If any injury or once.			5 Other (School)				tropo1	itan c 2. Name an				5-05	Al	exand	ria,	VA
Ba	Dep Imp		> //x	AH	Pless	MO01	73					Ebe	erwein White	Fun Pls	eral mr	Serv	
	TEL ()		23a. Part1. Enter mock, or hea	the disease, or art failure. List	complications only one caus	e on each	line.	ith. Do not en	er the mod	e of dyin	g, such as	cardiac o	r respiratory				Approximate Interval Between
- 14	Physician		In nediate Cause sease or conditi- resulting in death)	on	a	RES	PIRA	TORY		FF	91001	<i>RE</i>	•				Onset and Death
	/Medical Examiner						as a conse	quence of):	LUN	16	H	22 A					
	The State of the S	ner	Sequentially list co cause. Enter Und Cause (Disease of	onditions,	b		as a conse	wience off.									
	be executed sician and burial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	S	с	t- /		SHOK	ING								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	calE	, , , , , , , , , , , , , , , , , , , ,			or a duction	as a conse	quence of):									
687	tificate ig phys as the	77			0.											T	
Вох	Jeath certifica attending ph for use as th	an/N	23b. Was deceded in the past 12				ne of pregn 2 Fet		Ectopic pr	egnancy					23d. Date	e of delive	,
0.0	that the desired by the all detached for	Physician/Me	1 ☐ Yes 2 9 ☐ Unknown	□No		Pregnant Unknown	at time of	death 5	Other (sp	ecify)					MOI	itri	Day Year
٥.	res that tigned by	by Ph	Part II. Other signi	ficant conditio	ns contributir	ig to death	but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Dio	tobacco	use contri	ibute to th	e cause of death?
rds	w require been sig should b	led t		MOKI	νG,	-							Ne	Yes 2	2 □ No	3 Prob	ably 4 Unknown
Vital Records,	alawr as be a 2 sh	Completed												opsy	pi	rior to con	osy findings available inpletion of cause of
<u>a</u>	ysicien: The law is certificate has t director, page 2 s												1 ☐ Yes	formed2		eath?	e d No
\rightarrow	s certification	o Be	25. Was case refe examiner?		Hospital	li 🍎 Inpa	tient 2] ER/Outpatier	nt 3 DO	Othe			Check on ne 5 ☐ Re		6 DOth	e (Cassit	
סר	ding Phy h. After this funeral c	H .	27. Manner of Dea	th	28a.	Date of In		28b. Time o		8c. Injury Work			8d. Describe)
Sior	tendir death. tor: Af the fur	catic	Natural 2 ☐ Accident	5 Pending investig	ation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	М		Yes 2 ☐ I	No					
Division of	To the Hospital or Attending Physicien: within 42 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi			Injury - At h etc. (Speci	nome, farm, st ify)	eet, factory	, office		2		(Street a		er or Rura	Route Number,
	To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by	aic	29a. Certifier	Certifying	g Physician:	To the bea	st of my kn	owledge, deat	n occurred	at the tim	ie, date an	d place, a	ind due to th	e cause(:	s) and mar	nner as st	ated.
	the Ho nin 24 the Fu	ledical	(Check only one)	2 Medical E	xaminer: Or an	the basis d manner	of examin stated.	ation and/or in				th occurre	d at the time				
	To To con	Σ	29b, Signature and	title of certifier	20	HI				_	0 6 0 (628			ate signed		
0			30. Name and add	ress of person s	who complete			m 23a) /Tues	D-i-A)	_		-	1		6/6		
K	В		MENI	ONC	A NI	1 YA	JTA	RAN	1.	00	HOS	PRIN	OCE	FRE	506	RICL	L
	Sta	-	31. Date filed (Mor	199N 2 ar)	2005	32. P gis	strar's Sign	ature	1				HD				
	Registr	ar			_009	A Contraction		15 19	me	•							

			For State Registrar		aryland / Depa	artment of H rtificate of L			Reg. No. 1005	22708
	Physici /Medio	cal	Decedent's Name (First, Middle, Las Reginald As. Facility Name (If not institution, give	Brian	Jack		C. Location of Death	2. Date of De Month June	ath Day Year 22 2005 4c. County of Deat	3. Time of Death 5:30 P M
	Examir	ier	10914 Legend Mand 5. Social Security Number 6. Se	or Lane	ge (In yrs. last birthday)	Glendal If Under 1 Year Months Days			Prince G	eorge s
	Director t show	or	579-62-4566 Usual Residence of Decedent 10a. State MD Prince G	eorge's	10c. City, Town or Lo			Februar	cy 21 Was	hington,DC 10d. Inside City Limits 1X Yes 2□No
	ath with the I s 23s or 28s- oust be natif	Funeral Director	10e. Street and Number 10914 Legend Mano	r Lane		10f. Zip Code 2076			10g. Citizen of What Co	
9600	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show the Mailcel Exemiter must be mailled at	d by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 X If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	ecity Yes or No Rican, etc.)	Specify: B1	e, etc. .ack
21215-0036	ed within 72 tygiene. ygiene. ner than "net it, the Madica	Completed by	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work) 		Private	Industry
ryland	nould be fill d Mental H narked ott natic even	To Be	17. Father's Name (First, Middle, Last) Arthur Edwards 19a. Informant's Name/Relationship (7)	(man (Drint))	10h Maili	Address (Caret	Doro	thy Ja	Maiden Sumame) ckson er, City or Town, State, 2	7-0-4-
re, Maı	t and 2 st Health and tem 27 is n		Patricia A. Jack 20a. Method of Disposition		10914	Legend 1	Manor Lan		ale, Marylan 20c. Location - City or	d 20769
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23s or 28s-f show any Injury or other traumatic event. Ite Marical Examiner must be nutified at once.		1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specify)	Harmony 2		6/30 ss of Facility J.	B. Jen	Landover, kins Funera er, Marylar	1 Home
8760,	Physician / Medical Examiner and physician and physician and the printintial if the printintial in the printing of the printin	ai Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gast Due to (or a b. Due to (or a	of the death. Do not en					Approximate Interval Between Onset and Death
O. Box 687	eath certifi attending for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
σ.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions o	ontributing to death	but not resulting in the u	inderlying cause give	en in Part I.		obacco use contribute to Yes 2☑No 3☐Pr	the cause of death?
Vital Records,	The law ate has b page 2 st	e Completed	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	prior to death? 2X No 1 ☐ Yes	stopsy findings available completion of cause of 2図 No
of	Phys	To B	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpat	jury 28b. Time o		er: 4 Nursing Ho	ome 51 Resid	dence 6 □Other (Spe how injury occurred	cify)
Division	or Atten ifter deat Director: in by the	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28e. Place of I	njury - At home, farm, st	M 1 🗆	k? Yes 2 □ No	28f. Location (S City or Tox	Street and Number or Ru wn, State)	ural Route Number,
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edlcai C	29a. Certifier (Check only one) Certifying Ph	ysician: To the bes niner: On the basis and manners	of examination and/or in	h occurred at the tin evestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	withir To the To the Comp	M	29b. Signature and title of certifier	tal	-	29c. Licens	e number 18219		29d. Date signed (Mont.) June 27,	h, Day, Year) 2005
6	R (6)		30. Name and address of person who Stephen Staal	•	death (Item 23a) (Type	Print)		yland	20774	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 8 2005	A. Regis	trar's Signature	_			· · · · · · · · · · · · · · · · · · ·	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Month **Physician** June 25, 1:59 A M Dorothy Jean Kaplan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8 West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Min. Hours 1 □ M 2X F 1928 16, Director 76 232-44-6124 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20904 1113 Downs Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 le marked other than "natural", or Iter other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify. ģ 3 ☐Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) County Government Administrative Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Effie Berebitsky Thomas Rosenshine 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2030 Ednor Rd; Silver Spring MD 20905 Betsy Sirk - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 Burial 2 □ Cremation 3 □ Removal from State King David Memorial Park 6/28/05 Falls Church, VA ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Myclin 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RETROPERIZONEAL HEMBRAINALE **Physician** 20011 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 4No 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by IARDIOMYCPATHY 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2170 2 No 1 Tyes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After ! 5 Pending investigation 1 Matural М 1 Yes 2 No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 solu Te JUNE 25, 2005 123630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16226 FREGERZUE ROAD # 213 GAZTHERIBURG, MOZOITI J. MAYE 31. Date filed (Month, Day, Year) . Registrar's Signature State 2005 JUN 27 Registrar

			1 - For State Registrar		State o	f Maryla	nd / Depa	artment o			ental Hy	giene Reg. N		<u></u>	2071	0
		in.	Decedent's Name (First)	, Middle, Las	st)			inouto c	or Beatin		2. Date of D	eath		O ′ear	3. Time of De	
1	Physici /Medi				vid Leo		TIN				June 2	_	005		7:30	А м
	Examir	er	4a. Facility Name (If not in 13462 Villa	-		mber)			n, or Location Land	of Death		4c.	Howa	_		
	Funeral Director		5. Social Security Number 217-24-4563		ex ¶∑M 2□F	7. Age (In yr. 7)	s. last birthday) B Yrs.	If Under 1 You Months Da		Min.	B. Date of B. (Month, D.) June 1			9. Birthp Cour Mar	place (State or Fo	oreign
	and it		Usual Residence of Deced 10a. State 10b.	dent County	-	10c. (City, Town or Lo	cation						1	Od. Inside City L	Limits
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	h with the 23a or 28 st be no	ai Dire	10e. Street and Number 13462 Villa	dest 1	Drive			10f. Zip Cod	2077	7			izen of Wh		,	
960	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Evertinat mast Le	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ D	_	12. Was Deci Armed Fo 1 Tes If Yes, Gir Year or D	orces? 2√ No ve A		Was Decedent f Yes, specify (Cuban, Mexica	ın, Puerto P	cify Yes or Nican, etc.)	0-	14. Race Black, Specify:	White,		
1215-0036	within 72 h ene. than "natu he Mudical	mpleted	(Specify only Elementary/Secondary		ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Ockind of work do NOT use re Propr	one during mo:	st of workin	g		ind of Busi welry		·	
Maryland 21	ould be filed with Mental Hygiene. arked other than atic event, Ins.	o Be Co	12 17. Father's Name (First, I Abraham Kur						18. Moth		(First, Middl Harris	e, Maiden				
lary	2 shoul and Me is mark raumati	ř	19a. Informant's Name/Ro	elationship (Type, Print)			ng Address (Str								
e, N	1 and Health em 27 ther tr		William Kur 20a. Method of Disposition	<u>-</u>	Brothe		Place of Dispo	Ellico	f	Da	ate		ngton			3
MOF	Pages nent of int: If it		1 🖾 Burial 2 □ Crer `4 □ Donation 5 □ C	nation 3		State	cemetery, crer brew Yo	natory or other	place)	6 - 28 etery	-05		timor			
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Furieral	ervice Liger	1500			Name and Acorchins			uneral					
	40240		23a. Part1. =05 the dise	ase, or com	plications that o	aused the de	3							C 2	20012 Approximate Interval Betwee	
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Д	requires that the een signed by th hould be detache		Part II. Other significant of	conditions o	ontributing to d	eath but not re	sulting in the u	nderlying cause	given in Part	l.					ne cause of death	
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Vital	Physician: this certific ral director,	Be	25. Was case referred to examiner?	medical	Hospital:				Othor		(Check only					
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	5		30. Name and address of	person who	completed caus	se of death (It	<i>)</i> эт 23а) (Туре,	Print) Tali T	0029 Lliam K		n, M.F	<i>O</i> ,	/ ~ 3/	, 02	,	
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	Physic	ion	1. Decedent's Name (First, Middle							1	2. Date of Do	eath	-	<i>J</i>	3. Time of Death
	/Medi		Betty Ru								June	25,		Year	10:00 pM
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	Funeral		1717 Fairmount 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	-	Steac If Under 2		8. Date of Bi	ath.		rrol.	
Н	Director		218-24-7707	1□M 2√2F	76	Yrs.	Months	Days	Hours	Min.	(Month, Da	a <i>y, Year)</i>	928	Coun Mary	ace (State or Foreign try) Tano
	pu >		Usual Residence of Decedent 10a, State 10b, County		10.00						7100, 2.	L, .t.	720		
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	h with	DE	1717 Fairmour	it Road			102.p		1074			rog. Cii	USA		iry ?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neture!, or Items 23e or 28a-1 show any njury or other treumatic event, it a Modical Examinatine must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Fo	2∑No ve	11	Vas Deced Yes, spec		panic Orig , Mexican, Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.))-	14. Race	- America , White, e	
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Maryland	buld be f Mental H arked ot atic ever	Be c	17. Father's Name (First, Middle, Jacob Boerne)	,						_	(First, Middle /S Arma)	
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ore,	es 1 and 2 of Health I Item 27 I		20a. Method of Disposition	2 🗆 🗆		ace of Dispos	ition (Nam	e of			ate	-	ocation - C		vn, State
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	To the Hospitel or A within 24 hours after or to the Funeral Director Completely filled in by	ledical C	29a. Certifier (Check only one) Certifying 2 Medical E	g Physician: To the Examiner: On the ba and mann	isis of examination	riedge, death on and/or inve	occurred at estigation, i	t the time, in my opin	date and ion, death	place, ar occurred	nd due to the o	ause(s)	and mann place, and	er as stat f due to th	ed. ne cause(s)
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		_	1 - State Registrar		Cer	tificate of L	Death		Reg. N2 0	
	Physici /Medic		Decedent's Name (First, Middle, Last) Michael John Keg	oler				2. Date of De Month June	18	3. Time of Death 2005 6:26 P M
	Examir	ner	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death			nty of Death
	-		Carroll Hospital C 5. Social Security Number 6. Sex		thday)		Tunder 24 Hrs.	8. Date of Birt	th	roll 9. Birthplace (State or Foreign
	Funeral Director				Yrs.	Months Days	Hours Min.	Jan 06	у, Үөа <i>г)</i>	Birthplace (State or Foreigr Country) MD
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	20110	antion		- 0601 00	1700	10d. Inside City Limits
	shov	5				ninster				1 Yes 2 No
	28e-f	Director	MD Carro)TT ME	:5 U	10f. Zip Code			10g. Citizen o	of What Country?
	3a or	0	40 Wentworth Court			2	1158			USA
	death	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No Rican, etc.)	- 14. R	ace - American Indian, lack, White, etc.
Maryland 21215-0036	d within 72 hours after death with the Marylend liene. r than "natural", or items 23a or 28e-f show the Macical Examiner must be notified at	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Yes 25 No	Specify:		Spec	
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d 2	Hyg Hyg ent,		17. Father's Name (First, Middle, Last)			Master Pl	umber 18. Mother's Nam	e (First, Middle,		
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lary	and and is m		19a. Informant's Name/Relationship (Type			• •				m, State, Zip Code)
	1 and 3 Health tem 27 other tr		Mary Beth Endlich			entworth	The state of the s	estminst Date	•	
Jore	0 = 5		20a. Method of Disposition 1 ₩ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	y, crem	sition (Name of natory or other place	9) 6/23,		20c. Location	n - City or Town, State
Baltimore,			' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Deense			anch Cem			Wes	tminster, MD
Ba	permit. Departr importe any inje	1	W.Clan	40	Pr	ritts Fun	eral Home			
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4	Physician	E 15	Immediate Cause (Final disease or condition	Athenoscleroni c	and.	Diovascul	ar disea	se.		Onset and Death
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Вох	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		Ectopic pregnancy			1	Date of delivery Month Day Year
	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5	Other (specify)				
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ā	- 9	Certification:	4 Homicide	building, etc. (Specify)				City or Tov	vn, State)	
	To the Hospitel or within 24 hours efforthe Foundrai D completely filled in	edlcal (sician: To the best of my knowledge ner: On the basis of examination and and manner stated.						
	within To the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, Day, Year)
)			Jasher	leas MD		OCME			June	19 2005
	016		30. Name and address of person who co	mpleted cause of death (Item 23a) ((Туре,	Print) 111 Peni	n Street	Baltim	nore. M	arvland 21201
	, 4		Tasha Liveli 31. Date filed (Month, Day, Year)	32. Registrar's Signature						J
	St. Regist	ate rar	JUN 2 1 2			Corle				
		2001	JUN 2 1 2		7					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. N2 0 0 5 Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Deborah Kelly 1135 Jean 2005 20 June /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomuco Meningula Regional Medical Salisbun Uner If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months 1 ☐ M 2 🔀 F Director 216-58-7539 50 6/12/1955 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Show item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumetic event, it e manical Experient must be notified at 1X Yes 2 No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6486 Ford Circle 21801 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be nd Mental marked o Robert Harry Davis Jean Marie Marginot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Kelly/daughter 6486 Ford Circle, Salisbury, MD 21801 If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 6/22/05 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licens 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY DISTRESS SYNDROME ADULT Pnysician DAYJ disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 20 DA41 PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine LIVER DISEASE STAGE IYEAR END as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ ALCOHOLISM 1 Yes 2 No 3 Probably 4 Unknown Completed HEPATITIC CHRONIC 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Division of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital or 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 46962 JUNE 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER. MD 21081. 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) 3 7005 State Registrar

		•	For State Registrar	State of	Maryland		artment of H rtificate of L		ind Menta	l Hygier Reg. i		22714
N.			1. Decedent's Name (First, Middle	e, Last)					2. Date Mor	of Death	Day Year	3. Time of Death
	Physicia /Medic		Dorothy Irene	Kline					June	28	8 2005	2:00 P M
Ī	Examin		4a. Facility Name (If not institution	n, give street and num	iber)		4b. City, Town, or			4	tc. County of Dear	
1			Clearview Nur				Hager If Under 1 Year			-(0:	Washi	
н	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X() (F	7. Age <i>(In yrs. l</i> as 85	st <i>birtnday)</i> Yrs.	Months Days	Hours	Min. (Moi	of Birth nth, Day, Yea	ar) G	thplace (State or Foreign
	Director		219-05-2857 Usual Residence of Decedent		ره				Mar	. 13, 19	ZO Mi	aryland
	iand wo		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Mary Heh	ğ	Maryland Wash	ington			Will	iamsp	ort			1 ☐ Yes 2X☐ No
	r 28e	Directo	10e. Street and Number	1118.1011			10f. Zip Code			10g. (Citizen of What Co	ountry?
	h witi		10735 Bower A	venue				795			USA	
	deat	Funeral	11. Marital Status	12 Was Dece	dent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig	gin? (Specify Yes	s or No- etc.)	14. Race - Ame Black, Whit	
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215-0036	72 hours after death with the Maryland naturel', or Iteme 23e or 28e-f ehow disal Examiner must be notified at	d by	¥XWidowed 4 □ Divorced				• • • • • • • • • • • • • • • • • • • •	-41		105	Kind of Business	White
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Maryland	should Manual	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Addrass (Street a	and Numbe	r or Rural Route	Number, City	y or Town, State, .	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Depertment of Health and Mental Hyglene. Importent: If Item 27 is marked other then "naturel; or Iteme 23e or 28e-1 ehow eny injury or other treumatic event, the Madical Examinat must be notified at once.		Roy Kline - S	on		9005	Jordan R	d. Fa	irplay,	Maryla	nd 2173	3
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of Vital Records, P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, oute 1 Live bi 4 Pregna 9 Unknown ons contributing to de long igation 28a. Date of (Montriggation in ot be nined 28a. Place building Physician: To the lexaminer: On the baand manning the lexaminer: On the baand manning physician: To the lexaminer: On the baand manning phys	come of pregnance inth 2 Fetal of ant at time of dealers with the control of the	cy leath 3[tith 5[R/Outpaties 28b. Time of Injury ne, farm, st ledge, deaton and/or in	Dother (specify)	26. Place er: 4 yat yat Yes 2 1	23d 24d 1 [e. Did tobacc 1 Yes a. Was an autopsy performed? Yes 2 124 k only one) Residence scribe how in the cause of the cause of time, date at 29d.	23d. Date of de Month so use contribute to 2 No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spenjury occurred and Number or Rate)	Chronic Chr

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Mary Ann Josephine KIMMEL 415 A M 2005 June 27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital tagerstown Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. July 20, 1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1 □ M 2 🖾 F 213-24-8916 76 Maryland Director Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Expertment cast be notified at 1⊠Yes 2□No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 87 Wakefield Road 21740 IISA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc 2 should be filed within 72 hours after un and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2K Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify 2 white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gernard L. Shadrach Catherine Garling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a ant; If Item 27 is Charles M. Kimmel, Jr.-husband 87 Wakefield Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ò permit. Page Department of Important; If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 6/27/05 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 unnel or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause an each line. 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Du (or as a consequence of): Examiner 10 ma Social titles list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed veruso Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 20 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA the funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne eath 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the vest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a)-(Type, Print) ass 11110 Medica ample 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 28 2005 Registrar

			1 - For State Registrar	State of Maryla	-		of Health of Death		giene Reg. N2 () (05 22716
	Physici	ian	1. Decedent's Name (First, Middle, Last Leon Gail Kinsey					2. Date of De Month	Day	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give			4h City To	own, or Location	Nune	4c. County	2005 0939 AM
1	Examir	ner	Washington Count				Hagersto		,	ington County
	Funeral			7. Age (In yr.	s. last birthday)	If Under 1	Year If Under	24 Hrs. 8. Date of Bir		Birthplace (State or Foreign Country)
	Director		217-12-1545	M 2 F	9 Yrs.	Moriais	Days Hours	Min. (Month, Da Dec 28		Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ecation				10d. Inside City Limits
	Mary Fish	Ď	Maryland Washing	rton	Uncore	tour				1 X Yes 2 □ No
	th the	irec	10e. Street and Number	COII	Hagers	10f. Zip Co	ode		10g. Citizen of V	What Country?
	23a unt b	rai	1813 Winston Driv	<i>7</i> e			21740		United	States
	72 hours after death with the Maryland natural', or Itema 23a or 28a-f show dical Examirat must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent f Yes, specify	nt of Hispanic Or Cuban, Mexica	igin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No 8 – If Yes, Give Year or Dates: 8 _	26-46	1 □ Yes 2🔀	No Specify:	:	Specify	. White
21215-0036	2 hou atura	ted	15. Decedent's Edu	cation	16a, Dece	dent's Usual C	Occupation		16b. Kind of Bu	usiness/Industry
215	within 7 iene. than "n ire Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work of DO NOT use	done during mos retired)	st of working		,
121	filed withii Hygiene. other than		12			Owner			Restu	
and	d be fi	Be	17. Father's Name (First, Middle, Last)	1017			18. Moth	er's Name <i>(First, Middl</i> e) Staida Mae		10)
Maryland	2 should be f and Mental h is markad of aumatic ever	은	George Gail Kins 19a. Informant's Name/Relationship (Ty	•	19h Mailir	na Address /S	Street and Numb	er or Rural Route Numb		State Zin Code)
	5世代:		Ronald G. Kinsey					consboro Ma		21713
Baltimore,	of Head	1	20a. Method of Disposition		Place of Dispo cemetery, cren	sition (Name	of er place)	Date	20c. Location -	City or Town, State
Ë	nit. Pages ertment of l ortant; If Ita Injury or of		1X Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	RC RC	se Hill			une 27 05	Hagersto	own Maryland
3alt	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Licens	90 7	22	. Name and A	Address of Facili	^{ty} Douglas A	. Fiery	Funeral Home
			23a. Part1. Enter the disease, or compl	Xeny		31 Eas	tern Bl	vd. N. Hage	rstown N	Maryland 21742
			shock, or head failure. List only or Immediate Cause (Finat	ne cause on each line.	ath. Do not ent	er the mode o	or dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)	Due to (or as a cons	ideu	n h	Attic	118 (8/1	725	
	Examiner			Treat	nunt	for	Pur	11 men	d	
	D ==	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):	1-6	1 ., -	are contract		
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		and the state of t	Due to (or as a conse	iquence or):					
687	ficate physics from	Physician/Medical			-					
Вох	eath certific attending pl	N/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg					23d. Dat	e of delivery
B.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fei 4 ☐ Pregnant at time of 9 ☐ Unknown		lEctopic pregr l Other <i>(speci</i> i			Mor	nth Day Year
P.O.	that the de led by the s detached f	Phys	9 Unknown						9	
Ś	ires tha signed I be det	by	Part II. Other significant conditions con	stributing to death but not re	sulting in the ur	derlying caus	se given in Part I			ribute to the cause of death? 3 Probably 4 Unknown
)OIC	w requir been si should I	Completed	1 0 00 00 00 00 00 00	- 2 101	/ ×	SVICE	CHA	(2)		
Rec	The law ate has l page 2 s	id m	- Curry Piseas	e Mai	mut.	r 17.	m	24a. Was autop	osy ρ	Vere autopsy findings available prior to completion of cause of leath?
ā		ပိ	25. Was case referred to medical				00.00	1 ☐ Yes	20 No 1	Yes 2 No
Š	Physiclan: rthis certific ral director,	0 0	examiner?	ospital: 1x1npatient 2	☐ ER/Outpatien	3 DOA	Other	of Death (Check only our sing Home 5 Resident		or (Smails)
סר	ding Phys	T iu	27. Manner of Ceath	28a. ate of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		now injury occurre	
Sio	Attending r death. actor: After by the fune	catic	Natural 5 Pending investigation	(, 22)	,,	М	1 Yes 2	No		
	I or Attendater deatl	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre ify)	et, factory, of	ffice	28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
	pltal ours a aral (29a. Certifier Certifying Phys	inian: To the best of my kn	audodes desth		ha sima dasa an	<u> </u>		
	To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examin	sician: To the best of my kr ner: On the basis of examin and manner stated.	ation and/or inv	estigation, in	my opinion, dea	th occurred at the time,	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1		29c. Li	icense number		29d. Date signed	(Month, Day, Year)
			> Mayell	(num)	(10	23815		6.2	6.05
			30. Name and address of berson who co	mpleted cause of death (Ite	m 23a) (Type, I	Print)	11	. /		
-3			MATG EWM CY 1 31. Date filed (Month, Diniyear) Q 20	MY/ 354	W/11/3	Treet,	Hage	er stown,	W1/)	21740
	Sta Registr		5. 3ato indo (moning UN, 2, 8, 2)	32. Afgistrar's Sign	H. A.	rete	1	ť		

taped to me

Kinsey, Lean Gal

			1 - For Registrar	State of M	aryland			t of H	ealth a			giene	nns	22717
			Decedent's Name (First, Middle, Last,)	_						2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Patricia Maure	en Koch							June	23 ^{Day}	2005 ^{Year}	8:05 A M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death		4c. C	ounty of Dea	th
			2704 Birdseye Lane	<u>, </u>				Bowi	.e					eorge's
	Funeral Director		5. Social Security Number 6. Sec. 408-80-9313	7. Ag	ge (In yrs. la 58	ast birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Day June 30	, 194	9. Bir 6 I11	thplace (State or Foreign ountry) inois
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Many -1 sh	ţō	MD Prince Ge	eorge's		Bowie								1 XYes 2 No
	r 28g	Funeral Director	10e. Street and Number	0			10f. Zip	Code				10g. Citize	n of What Co	ountry?
	th wit	alD	2704 Birdseye Lan	ne				2	20715			US.	A	
	ams ams	ıner	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13. \	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	. 14	Race - Ame	
36	or it	by F.	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No		I□Yes 2		Specify:		, , , , , ,			
Ö	tural'	q pe	3 Widowed 4 Divorced	Year or Dates:		16a Dans	loni's Unio	1.000	****				WII	ite
5	within 72 hours after death with the Maryland ena. than "natural", or itams 23s or 28a-1 show the Marical Examilian cust be confilled at	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		16a. Deced (Give life. L	kind of wor DO NOT us	rk done d	lurina most	of worki	ng	16b. Kind	of Business	Industry
212	iena.	E O	Elementary/Secondary (0-12)	College (1-4or:	5+)		giste			9		Nur	sing	
פ	e fillad v Il Hygie othar t	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,			
<u>Jar</u>	uld by Venta rrkad rtic e	ToE	Patrick McLaughli	n					C1a	are (Costello)		
Maryland 21215-0036	2 sho and I is ma		19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	I Route Numbe	r, City or T	own, State,	Zip Code)
	and ealth m 27		S. Jeffery Koch /	spouse	1	2704					owie, M		0715	
Baltimore,	Pagas 1 nent of H int: If ital		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State		ace of Dispo emetery, cren					ate		tion - City or	
Ē	tmen tant:		'4 □Donation 5 □ Other (Specify)		Met	ropoli	tan C	rema	tory	06/2	28/2005	Alexa	andria	, VA.
Ba	permit. Pagas 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If itam 27 is merked other than "natural", or itams 23s or 28s-1 show any injury or other traumatic event, the Marylical Extra in a 15s notified at once.		21. Signature of Funeral Service Licens	Mean	1	6	512 N	W Cr	ain F	łwy.	all Fund Bowie	MD.	Home 2071	5
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	d the death ine.	. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	. Systemi			ythema	atos	is					
	Examiner			Due to (or as	a consequ	ience of):								
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	d d ansit	Examiner	Cause Disease or injury	c.										
o,	an an rial-tr	Еха	resulting in death) Last	Due to (or as	a consequ	ience of):								
3760,	The law requires that the death certificate be executed to has been signed by the attanding physician and bage 2 should be detached for use as the burial-transit	cal		d										
39	artifica ing ph e as t	Physiclan/Medl	IF FEMALE:											_
Вох	res that the death certific igned by the attanding p be detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pre					230	d. Date of del Month	ivery Day Year
0	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	eath 5	Other (spe	ecify)		-			19101111	Day Tour
٥.	that the ed by detac		Part II. Other significant conditions con	ntributing to death b	out not resu	itting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
Records,	uires sign id be	d by	Gastric p				, ,							obably 4 Munknown
000	w require been si should l	lete							-		24a. Was	20	24h Wara au	Itopsy findings available
Re	he lav e has age 2	Completed									autop perfor	med/	prior to death?	completion of cause of
Vital		a	25. Was case referred to medical						26 Place	of Death	1 Yes	2 No	1 🗆 Yes	2 No
<u> </u>	ysician: The is certificate h director, page	To B	eyaminer? /	fospital:	ent 2 🗆 E	ER/Outpatien	t 3 🗆 DO	A Othe			ne 5 Resid		Other (Spe	cify)
0	Attending Physician: r death, ector: After this certifica by the funeral director, I		27. Manyer of Death	28a. Date of Inju (Month, Da	ury v Year)	28b. Time of Injury	28	Bc. Injury Work	at		28d. Describe h			//
Ö	teath, tor: Af the fur	atlo	1 Natural 5 Pending 2 Accident investigation	(,		,,	М		/es 2 □!	No				
Division of	or Att	ertification;	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At hor tc. (Specify	me, farm, str	eet, factory,	, office		2	28f. Location (S City or Tow		lumber or Ru	ıral Route Number,
	urs af urs af ral D	O												
	To tha Hospital or Attentwithin 24 hours after deatl To tha Funaral Director: completely fillad in by the	edical	29a. Certifier 1 Certifying Phy: (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner st	of examinati	wledge, death ion and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurre	and due to the o ed at the time, o	ause(s) an date and pl	id manner as ace, and due	stated. to the cause(s)
	To ti Withi To ti	ž	29b. Signature and title of certifier	01					number			29d. Date s	igned (Monti	h, Day, Year)
	. 0		1 Tour	-h	100	7	1	23	140	2		4/24	1/5	
0	R (10)		30. Name and address of person who co								D	3.4	4	00715
	Sta	tė	George Kavanagh N 31. Date filed (Month, Day, Year)	Registr	rar's Signat	บเอ		oad,	Suite	e 10:	2, BOWI	e, Ma	ry⊥and	20/15
H	Registr		JUN 2 7 2005	Blown	, it	loon	E)							

	For State		State of M	-		ment of Fi	lealth and N Death	Mental H	ygien Reg. N	~ ~ ~	22710
	Registrar 1. Decedent's Name	(First, Middle, La	ast)			10010 01	Douin	2. Date of D		000	3. Time of Death
n			,					Month		ay Yeer 9 2005	
l I	Gene Piet		ve street and number)	41	City Town o	r Location of Death	June		c. County of Dea	
1		ta Court				Lusby				Calvert	
	5. Social Security N	umber 6.	Sex 7. Ag	ge (In yrs. last birti		Under 1 Year	If Under 24 Hrs.	8. Date of B	irth		rthplace (State or Foreign ountry)
	214-84-86	005	1 ⊠ M 2□F	43	rs. M	onths Days	Hours Min.	Dec. 2		961 Vir	ountry) ginia
	Usual Residence of										
_	10a. State	10b. County		10c. City, Town	or Location	on					10d. Inside City Limits
200	Maryland	Calver	t	Lusby							
ב	10e. Street and Nun	nber			1	Of. Zip Code			10g. C	itizen of What C	ountry?
ā	_933 Mino	t Court				20657				ted Sta	
nue Cur	11. Marital Status		12. Was Decedent Armed Forces	?	13. Was	Decedent of H s, specify Cub	fispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
×	3 ☐ Widowed	ed 2 Married	1 ☐ Yes 2 📆 If Yes, Give Year or Dates:	No	1 🗆	Yes 2⊠ No	Specify:			Specify:	1.4
ear		15. Decedent's 8		16a	Decedent	's Usual Occup	pation	-	16b	Kind of Business	hite
pier		ify only highest gi	rade completed)		(Give kind	l of work done NOT use retire	during most of work	ring			
completed by runer	Elementary/Secon	ndary (0-12)	College (1-4or		lf Er	nployed			HV	ACR Mec	hanic
e C	17. Father's Name (First, Middle, Las	t)				18. Mother's Name	e (First, Middl	e, Maide	n Sumame)	
0	Stanley 1	Eugene L	ahargoue				Janice W	loltz			
	19a. Informant's Na	me/Relationship	(Type, Print)	19b.	Mailing A	ddress (Street	and Number or Run	al Route Num	ber, City	or Town, State,	Zip Code)
	Ann Mari	e Holt	(Exwife)	93	3 Mi	not Cou	rt, Lusby	, MD 2	0657	•	
	20a. Method of Disp			20b. Place of cemeter	Disposition, cremato	n (Name of ary or other pla	ce)	Date	20c. l	Location - City or	Town, State
		5 Other (Spec	□Removal from State ify)		olita	an Crem	atory 6/	22/05	Ale	xandria	, Virginia
	21. Signature of Fu	neral Service Lice	ensee		22. Na	ame and Addre	ss of Facility De	Vol Fu			
	Yobe	th XI	Wol		Gai	thersbu	er Park D	877			
	23a. Part1. Exter the	ne disease, or con nt failure. List only	mplications that cause y one cause on each I	d the death. Do n ine.	ot enter th	ne mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Immediate Cause (disease or condition		· anst	cointes	sting	1 he	morphae	e			Onset and Death
	resulting in death)	-	Due to (or as	a consequence o	of):			1			
	Sequentially list cor										
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Xall	if any, leading to im cause. Enter Unde that initiated events resulting in death) L	riving injury	c	-		cer					
al Examin	Cause (Disease or that initiated events resulting in death) L	riving injury	c	a consequence of		cer					
dical Exam	that initiated events resulting in death) L	riving injury	c	-		cer					
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edical	IF FEMALE: 23b. Was decedent in the past 12	imediate rhying ast ast pregnant months?	c. Due to (or as d	e of pregnancy	of): 3 □Ect	opic pregnance	,			23d. Date of de Month	livery Day Year
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State Registrar

10

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Pnysician /Medical Examiner

been signed by the attending physician and should be detached for use as the burial-transit

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Registrar's Signature

			1 - For State Registrar	State of Maryla		artment of I rtificate of		Re	· P115	22719
	Physici		Decedent's Name (First, Middle, Last) Madeline Lee					June 21,		3. Time of Death 8:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give the Holy Cross Hospit			1	or Location of Dear	th	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 219-64-6454	-X	rs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birt 1953 Wash	hplace (State or Foreign untry) nington DC
	anyland show dat	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	the Ma 28e-f	Directo	Maryland Montgomes 10e. Street and Number	У	Rockvil:	Le 10f. Zip Code	•	10	g. Citizen of What Co	1 A Yes 2 No
	th with 23a or ust be	al Di	7233 Deer Lake La	ine		2085	5		USA	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie markad other than "netural", or Itams 23a or 28e-f show early injury or page traumatic event, the Madical Examinating the natified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ♠No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: As	
15-0	n 72 ho "netu	letec	15. Decedent's Edu (Specify only highest grade		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	oation during most of wo d)	orking 1	6b. Kind of Business/	Industry
212	ed withi	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		uter Spec			Federal Go	overnment
Maryland 21215-0036	d be file antal Hy and oth	Be (17. Father's Name (First, Middle, Last)					me (First, Middle, M.	aiden Sumame)	
aryl	should and Me le mark	T ₀	Art Ping Lee 19a. Informant's Name/Relationship (<i>Ty</i>	pe, Print)	19b. Maili	ng Address (Street		ing Tam ural Route Number,	City or Town, State, Z	Tip Code)
e,	1 and 2 Health em 27 I		Donald Y. Hsia - I		1622		ham Dr;		n MD 20874	
E	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	amoval from State	cemetery, crei	natory or other pla		la.	Silver Spr	
Baltimore,	permit. Departm Imports eny inju		21. Signature of Funeral Service Licenson	loved	1	1800 New	Hampshir	e Ave; Si	lver Sprin	al Home, Inc ng MD 20904
7	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the de ne cause on each line. Metastat				c or respiratory arres	st,	Approximate Interval Between Onset and Death O MONTHS
	/Medical Examiner		1	Due to (or as a cons	sequence of):					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of);					
8760,	ate ba exacuted obysician and the burial-transit	Ical	resulting in death) Last	Due to (or as a cons	sequence of):					
P.O. Box 6	death cartific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preduction of the second of the se	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
	law requires that the de as been signed by the z 2 should be detached t	by	Part II. Other significant conditions cor Polyneuropathy	ntributing to death but not a	resulting in the u	nderlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
Vital Records,	The ate ha	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
Vita	Phyeicien: Th this certificate ral diractor, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 😾 Inpatient 2	☐ ER/Outpatier	it 3□ DOA Ot		ath Check on one	ce 6 □Other (Spec	
ion of	ding h. After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Inju Wo	ry at rk? Yes 2 No	28d. Describe how		iny)
Division	el or Atten s after deal I Director: d in by the	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Al within 24 hours after of To the Funarel Direct completely filled in by	edical C	29a. Certifier 1 X Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my later: On the basis of exame and manner stated.	knowledge, deatl ination and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
)		M	29b. Signature and title of certifier	12.00		29c. Licen: D3599		296	d. Date signed (Month 6/22/2005	
	(0		30. Time and address of person which Linda M Burrell, M	m leted cause of death (I D 2730 Uni			0: Wheat	on MD 209	02	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7 200	327 Registrar's Sig			,			

iar	1.	State Registrar . Decedent's Name (First, Middle, Las	st)	-		ate of Dea	alli	2. Date of D	eath	2005	3. Time of Death
		Mary I	Louise Ligg	ott				Month 06/19/	Da 2005	y Year	11:33P
ca nei		a. Facility Name (If not institution, give			4b. Cit	ty, Town, or Loca	ation of Death			. County of Dea	ath
		Hillhaven Nursing	g Home			delphi			P	rince C	George's
		Social Security Number 6. S	□M 242F	(In yrs. last birt	hday) If Und Month		Jnder 24 Hrs. ours Min.	8. Date of B (Month, D			rthplace (State or Fore Country)
		579-12-4521 Isual Residence of Decedent	8	5				09/01	/191	9 Was	shington, D
		0a. State 10b. County		10c. City, Town	or Location						10d. Inside City Lim
Emeral Director		Delaware		Lewes	i						1 □ Yes 2√1
2	10	0e. Street and Number				Zip Code			10g. Cit	izen of What C	Country?
Orgi	3 1	135 E. Quail Trai	12. Was Decedent Ev	ver in U.S.		19958	nic Origin? (S	necify Yes or N	0-	U.S.A.	
Ē	3	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No			cedent of Hispan pecify Cuban, Me		o Rican, etc.)		Black, Wh	ite, etc.
Š	2	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2☐No Sp	ecify:			Specify: wh	ite
Completed		15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a.	(Give kind of v	sual Occupation	g most of wor	king	16b. K	ind of Busines:	s/Industry
2		Elementary/Secondary (0-12)	College (1-4or 5+)	`lifa. DO NOT	use retired)		-			
5	1	7. Father's Name (First, Middle, Last)	2	S	ecreta		Mother's Nan	ne (First, Middl		overnme	nt
To Bo	i	John William Grad					C1a		ahm	,	
۲		19a. Informant's Name/Relationship (19b.	Mailing Addre	ess (Street and N		CONTRACTOR OF THE PARTY OF THE		or Town, State,	Zip Code)
		William Liggett/S	Son	135	E. Qu	ail Tra:	il Lew	es, DE	1995	8	
	20	0a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter)	Disposition (Ny, crematory of	lame of r other place)		Date	20c. Lo	ocation - City o	r Town, State
		*4 □ Donation 5 □ Other (Specify	y)	Fort L	incoln	Cemeter	ry 6/2	4/2005	Brei	ntwood,	MD
	2	21. Signature of Funeral Service Licen	800			and Address of					
		yan T. //	led and the same of the	ha daath Da a		Bladens				d, MD 2	
	-	23a. Part/. Enter the disease, or of my shock, or heart failure. List only	piications that caused t		ot ontor the m	and of duine cur	ah ac cardiac	or receiratens	0 *** 0 0 0		
	- In	The second secon).				or respiratory		100	Approximate Interval Between Onset and Death
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	ri ri	mmediate Cause (Final disease or condition resulting in death)	a. ATHERO Due to (or as a	sciero	TIC (-		1 50	Interval Between Onset and Death
ner	d n	mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions,	a. ATHERW Due to (or as a	sciero	う で((of):			-		150	Interval Between Onset and Death
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edical Certification: To Be Completed by Physician/Medical Examin	S CC ttr re 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	issass or condition esulting in death) Sequentially list conditions, any, leading to include ause. Enter Underlying ause. Enter Underlying hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions or examiner? 1 Yes 2 No 5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 19a. Certifier (Check only one) Medical Examiner) 19a. Certifier (Check only one) Certifying Phase Certi	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome or 1	consequence of conseq	patient 3 [I ime of jujury M m, street, factor death occurred for investigation 2	pregnancy (specify)	Part I. Place of Dea Nursing H 2 □ No atte and place, o, death occur aber 1 5 6	23e. Did 1 1 24a. Wha auto performed at the time 28d. Describe 28f. Location City or To	tobacco u Yes 2 S an opsy ormed? 25 No one) idence how injur (Street an own, State e cause(s), date anc 29d. Dat	23d. Date of de Month Use contribute t No 3 P 24b. Were a prior to death? 1 Ve. 6 Other (Spery occurred) and manner a d place, and du te signed (Month)	Interval Between Onset and Death Onset and Death Service of the cause of death? Probably 4 (Munknow Intropy findings availat completion of cause of secify) Pural Route Number, Stated. The total Between Onset and Death Probably American Service Onset Interval Between Onset Interval Death Interval Between Onset Interval Death Interval Between Onset Interval Death Interval D

				artment of Health and Mental	Hygiene Reg. N2 0 0 5 2 2 7 2 2
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Charles H. Lewis 4a. Facility Name (If not institution, give street and number)	Mon	27, 2005 6:14 AM
	Funeral	ei -	77 Dixon Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Aberdeen	Harford
	Director -I show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		704/1927 Virginia 10d. Inside City Limits ¥24Yes 2 □ No
	d within 72 hours after death with the Maryland piene. r than "naturel", or Items 23a or 28e-f show the Medical Evantiner coust be notified at	Funeral Director	10e. Street and Number 77 Dixon Avenue	10f. Zip Code 21001 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	10g. Citizen of What Country? U.S.A. s or No- tc.) 14. Race - American Indian, Black, White, etc.
21215-0036		Completed by I	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 Yes 2 No Specify: defent's Usual Occupation a kind of work done during most of working DO NOT use retired)	Specify: White 16b. Kind of Business/Industry
Maryland 21	2 should be filed withir and Mental Hygiene. Is marked other than reumatic event, the M	To Be Con	3 0 17. Father's Name (First, Middle, Last) Willie R. Lewis	Manfacturing 18. Mother's Name (First, Manne (First, Manne) Eliza Dav	is
altimore, Mar	l and lealth om 27 her ti		Robert J. Lewis (son) 179 I 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State	Engle Avenue, Aberdeen osition (Name of matory or other place) Date of motory or other place) Date of motory or other place) Date of motory or other place) O7/01/2005	, MD 21001 20c. Location - City or Town, State
Balti	permit. Pages Department of t Importent: If Ite any injury or of		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Arring-Cargo Funeral Home, 33. South Parke Street, Abern	P.A. deen, MD 21001
8760,	Certificate be executed Medical Examiner Ading physician and See as the burial-transit	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C	COPD	Interval Between Onset and Death
.O. Box 6	the death certif y the attending iched for use a:	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
of Vital Records, P	The law requires ete has been sign page 2 should be	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the prostate Cancer Hypertensive Cardeovas	eular diseas 24a	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? performed? Tes 2 No 1 Yes 2 No
sion of Vita	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1	26. Place of Death Check	
Division	5 th C	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	City	ation (Street and Number or Rural Route Number, or Town, State) to the cause(s) and manner as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medi	29b. Signature and title of certifier Suan (Sec. MD, FACC	29c. License number D 00 1515 2	## Harford Birth Day Year) 4/1927 Sinthplace (State or Foreign Country)
5			30. Name and address of person who confipleted cause of death (Item 23a) (Type Brian T - Yeo, M.D. 801 5. U	nom Ave. Navre de	Grace, MD 21078

05-4374 B.K.S BRIA

M J. LA	PP	1 _ State	iteli#23a. State o	Marylar Marylar				nd Mental Hy	ygiene	0.0 -	
		Registrar 1. Decedent's Name (First, Middle	a. Last)		Cel	rtificate of	Death	2. Date of D	Reg. No.	2005	3. Time of Deader
Physic /Med		Brian	Jonat	han		Lapp		JUNE	28,	2005	1525 P ^M
Exami		4a. Facility Name (If not institution 21452 SOUTH ES	s, give street and nui SEX DRIVE	mber)		4b. City, Town, LEXING	or Location of C	RK	4c. C ST	ounty of Death MARY"S	
, Funeral Director		5. Social Security Number 214 64 6600	6. Sex 1 1 2 ☐ F	7. Age (<i>In yr</i> s. 46		If Under 1 Year Months Days		Min. 8. Date of B	irth 21, Year)	9. Birthp Cour 958 Ma	place (State or Foreign ntry) ryland
tand ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	10d. Inside City Limits
a-feh	ctor	MD St. M	ary's		Lexin	gton Pari	k				XX Yes 2 ☐ No
3s or 28	i Dire	10e. Street and Number 21452 South E	ssex Driv	е		10f. Zip Code 2i	0653			en of What Coul	ntry?
ife, MidIfylding ZIZID-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or flems 23a or 28a-1 show other traumatic event, the Medical Examinations must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed **XXDivorced**	Armed Fo	2 □ No 1	984 -	Was Decedent of If Yes, specify Cub		n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
72 hou	ted	15. Deceden	t's Education	,,,,	16a. Dece	dent's Usual Occu kind of work done	pation	f working	16b. Kind	d of Business/in	
within ne.	Completed	Elementary/Secondary (0-12)	College (I-4or 5+)	life.	ctronics	ed)	•		Arriatio	-n
filed villed other ent, tr	0	17. Father's Name (First, Middle,	Last)		Die	CCLOTICS	, <u>-</u>	Name (First, Middl	e, Maiden S	Aviatio)II
should be fill and Mental H is marked oth	To B	Herbert W	alter	Lapp			Lor	raine		Traei	nkle
VICE Sho		19a. Informant's Name/Relations						or Rural Route Num			•
Health tem 27		Herbert W. La 20a. Method of Disposition	рр, м.р.	20b.		Murphy I esition (Name of matory or other pla		erkeley S		s WV 25 ation - City or To	
2 82=5		1 ☐ Burial ②CCremation 4 ☐ Donation 5 ☐ Other (S		State		n Cremato n Cremato	h	7/2/05	Hage	erstown	, MD
Calling Charles Calling Charles Cha		21 Signature of Funeral Service 23a. P 1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that conly one cause on a	each line.	th. Do not ent	5 Union S	St., Reing, such as ca		rings,		111-1855 Approximate Interval Between Onset and Death
ate be executed x3 minus in the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consec	Quence of):						
Geath certific death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live t	tcome of pregn birth 2 Fet nant at time of c	at death 3	Ectopic pregnance Other (specify)	гу		23	3d. Date of delive	ery Day Year
w requires thet the been signed by the should be detached	Ď	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the u	nderlying cause g	ven in Part I.			e contribute to the	he cause of death?
The lay	Completed							24a. Wa auto per 1/2 Yes	s an opsy formed?	24b. Were auto prior to co death? 1 X Yes	psy findings available impletion of cause of
OT VICAL Physician: 1 this certifical ral director, p	Be	25. Was case referred to medica examiner?	Hospital:			C		f Death (Check only			
	n: To	Yes 2 No 27. Manner of Death	1 1 1 1	Inpatient 2 of Injury th, Day Year)	28b. Time o	11 3L DOA	4 🗆 190151	ing Home 5 Res			y) AT SCENE
VISION (Attending I ar death. ector: After by the funer	atlo	1 Natural 5 Pendir 2 Accident investi	gation	m, Day Year)	Injury		ork?]Yes 2∐No	.			
₹ 5 € 5 .⊆	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place	of Injury - At I ing, etc. (Spec	nome, farm, str ify)	reet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rura	al Route Number,
Hos Tur Bely	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred at the to vestigation, in my	ime, date and i opinion, death	place, and due to the occurred at the time	e cause(s) a e, date and p	and manner as s place, and due to	tated. o the cause(s)
	Σ	29b. Signature and title of certifie	e Ha	clav	wa	29c. Licen OC	se number ME			signed (Month, E 29, 20	- '
(12+1)		30. Name and address of person	- HALL	ANN	D	Print)	enn Str	eet Balt	imore	, Maryla	and 21201
S Regis	tate trar	31. Date filed (Month; Day, Year,	1 2005	Règistrar's Sign		1					
DHMH 17 Rev 1	- 10	002.1	~ (000)	KHM	D A						· · · · · · · · · · · · · · · · · · ·

			1 - For State of Registrar	Maryland / Depa	artment of Health and M rtificate of Death	lental Hygie	ne N2005	22724
	Physici /Medic		1. Decedent's Name (First, Middle, Last) HELEN FRANCES LEWIS			2. Date of Death Month JULY 3	Day Year 2005	3. Time of Death 0458 M
	Examir		4a. Facility Name (If not institution, give street and num FROSTBURG VILLAGE NURSIN		4b. City, Town, or Location of Death FROSTBURG		4c. County of Deat	
	Funeral Director		5. Social Security Number 215 14 6273 Usual Residence of Decedent	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye APRIL 11	9. Birt Co 1921 MAF	hplace (State or Foreign untry) XYLAND
	e Maryland Ba-f chow	ctor	10a. State 10b. County MARYLAND ALLEGANY	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes ※ No
	h with th	Funeral Director	10e. Street and Number $10111 \;\; BOSTON \;\; ROAD \;, \;\; NW$		10f. Zip Code 2 15 3 2		Citizen of What Co	untry?
036	be filed within 72 hours efter death with the Maryland tal Hygiene. dothar than "natural", or Items 23a or 28a-1 ehow event, the Medical Exami ar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Dece Armed For 1 Yes, Signify Yes, Given Year or Day	2 X No	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) SEAMSTRESS	ing	HIRT FACT	
Maryland	should be filed nd Mental Hygis marked othar umatic evant, II	To Be C	17. Father's Name (First, Middle, Last) THOMAS WRIGHT		18. Mother's Name TRENA	e (First, Middle, Mai PAPE	den Sumame)	
	nd 2 s		19a. Informant's Name/Relationship (Type, Print) MARTIN LEWIS / SON		ng Address <i>(Street and Number or Rura</i> 02 TANGLEWOOD COUR		-	
Baltimore,	nit. Page: artment o ortant: If Injury or 8.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5 '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee	ST. MICHA	TABL CEMETERY 7/6 Name and Address of Facility	/05 FR	0 W. MAIN	MD 21532 STREET
8	Dep Imp any		23a. Part1. Enter the disease, or complications that consock, or heart failure. List only one cause on each	used the death. Do not en	OWERS FUNERAL HOME ter the mode of dying, such as cardiac of		ROSTBURG,	Approximate
	Physician /Medical Examiner	J.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	or as a consequence of): Al 2 h or as a conseque c3 of):	ementia limers Dis	e ase		5 years 5 years
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):				
P.O. Box 6	at the death certific by the attending p tached for use as I	Physiclan/Med	in the past 12 months?	ant at time of death 5	⊒Ectopic pregnancy ☐ Other <i>(specify)</i>		23d. Date of deli Month	very Day Year
	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to de					. /
I Records,		Completed	Old age: mutstin and	Fluids	`	24a. Was an autopsy performed	prior to death?	ompletion of cause of
ion of Vital	Physician: r this certific ral director.	To Be		npatient 2 ER/Outpatier f Injury n, Day Year) 28b. Time o	nt 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 28d. Describe how i		ify)
Division	al or Attendis after death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, str g, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba and mann	sis of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	Interval Between Onset and Death S Year S 5 Year 5 5 Year 5 1 Day Year S atte of delivery onth Day Year S attribute to the cause of death? 3 Probably 4 Munknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ther (Specify) rred ther or Rural Route Number, anner as stated, and due to the cause(s) and (Month, Day, Year)
	To th withir To th comp	Me	29b. Signature and title of certifier	Sandhirt	29c. License number D 144 6	5 4 ^{29d.}	Date signed (Month	2005
_	1		30. Name and address of person who completed caus S. L. SANDHIR, 48 TARN					
	Sta Registr		31. Date filed (Month, Day, Year) 32. R	gistrar's Signature	hack is			

			1 - For Stete Registrar	State of	Marylan	id / Depa		t of H	lealth a		ental Hyg		205	227	25
	Physici	an	1. Decedent's Name (First, Middle, La	st)									Year		
	/Media		Carl Franklin								June	26	2005 2725 ay Year 6 2005 3. Time of Death		
	Examir	ner	4a. Facility Name (If not institution, giv		er)					of Death		ygiene Reg. N2 0 0 5 2 2 7 2 5 Death Day Year 26 2005 / 23 / M 4c. County of Death Washington Sirth Day, Year) 9, 1944 9. Birthplace (State or Foreign Country) 9, 1944 Maryland 10d. Inside City Limits 1			
	Comment		8332 Reichard I		Age (In yrs.	last birthday)	If Under	airp 1 Year		2. Date of Death Month Day Year 26 2005 23 M Month Day Year 26 2005 23 M Month Day Year 26 2005 23 M Month Day Year 26 2005 23 M Month Day Year 26 2005 23 M May 19, 1944 Washington 9. Birthplace (State or Foreign Country) Mary I and May 19, 1944 Mary I and Mary I and May 19, 1944 Mary I and Mary I and Month Day Year 100. Inside City Limits					
	Funeral Director			1 XM 2□ F	61	Yrs.	Months	Days	Hours	Min.	d Mental Hygiene Reg. N2 0 0 5 2 2 7 2 5 2. Date of Death Month June 26 2005 4c. County of Death Washington dis. 8. Date of Birth (Month, Day, Year) May 19,1944 10d. Inside City Limits 1 □ Yes ★★No 10g. Citizen of What Country? USA 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White working 16b. Kind of Business/Industry Fire Protection Name (First, Middle, Maiden Sumame) In a Frances Litten Rural Route Number, City or Town, State, Zip Code) airplay, Maryland 21733 Date 20c. Location - City or Town, State 18e 30,200				
yland	Mou		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
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Ē.	or 28	Funeral Director	10e. Street and Number				10f. Zip					0g. Citizen	of What Co	untry?	
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er de	itams	nne	11. Marital Status 1 ☐ Never Married 2 🗙 Married	12. Was Deced	es?		Was Deced If Yes, spec	ent of H ify Cuba	ispanic Ori in, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	14.			
21215-0036 Id within 72 hours after death with the Maryland	o la	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	□ № 196 s: 196		1□Yes 2	≥ <mark>X</mark> No	Specify:			Spi	ecify:	lhite	
5-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0	cal F	Completed	15. Decedent's E			16a. Dece	dent's Usua	I Occup	ation	1 - 4	_	16b. Kind o			
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Maryland	and Mental Hygiene. s markad other then " umatic event, the Max	Be	17. Father's Name (First, Middle, Last								,		,		
aryla	nd Me mark matic	은	Paul Franklin 19a. Informant's Name/Relationship	Litten Type, Print)		19b. Maili	na Address	(Street :						7in Code)	
- N	CO 65		Elizabeth C. Lit												
re ,	Department of Health Importent: If Item 27 is any injury or other traduce.	-	20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	ا (م						
mor Pages	nut: If		1 XX gurial 2 ☐ Cremation 3 ☐ 14 ☐ Dowation 5 ☐ Other (Speci		ater i	nor Cer				une :	30,2005	Tild	manto	n Mary	land
Baltimore,	porte porte y inju		21. Signature of Funeral Service Lice	nsee)		Os	borene	A Fide	Helicabili	y HOIII	e, r.A.			Shington Shington Shington Shinplace (State or Foreign Country) Maryland 10d. Inside City Limits 1	
m 8	9 2 2 9		cuy/14	21		42	25 S.	Con	ococh	eagu	e St. W	Illian	3. Time of Death Year 2005 County of Death Washington 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1		
,	iysician Medical		23a. Part1. Enter M disease, or son shock, or heard failure. List only Immediate Cause (Final disease or condition resulting in death)	a	Najo	phary						est.		Interval Bet Onset and	tween Death
	caminer		1	Due to (or	as a conseq	luence of):									
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00, e axe	ian ar urial-t	EX	resulting in death) Last	Due to (or	as a conseq	juence of):						-			
8760,	physic the b	dicai		d											
. Box 68760, death certificate be axecuted	signec by the attending phys	by Physician/Med	IF FEMALE:	23c. If yes, outco	me of pream	ancy.						Ī			
Box eath cert	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birt	h 2 Feta	death 3	Ectopic pro		,			23d.			Year
o. ₽	y the	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow		52	2 O (1101 (3p)	JUNY							
D 2	ned b	y P	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying c	ause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of o	death?
Records,	been sig should b										1 🗹 Y	es 2 N	o 3 🗌 Pr	obably 4 🗍	Unknown
eCO aw re	s been 2 should	plet											4b. Were au	topsy findings	available
	ate ha	Completed									perfor	med?	death?		ause or
Vital	ertific ector.	Be	25. Was case referred to medical examiner?					7						1052	
of Vital Physician:	this certificate has al director, page 2	2	1 Yes 2 No			ER/Outpatier								city)	
On Sing	h. After thi funeral	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month)	Day Year)	28b. Time o Injury	f 2 M	8c. Injun Worl	yat k? Yes 2⊡I		28d. Describe h	ow injury oc	curred		
Division for Attending	death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	OB Disco o	f Iniury - At h	ome, farm, st			163 201		28f. Location (S	treet and N	umber or Ru	ıral Route Num	nber.
Div	Dire d in b	erti	4 Homicide determined	building	, etc. (Specif	fy)		, 000]	City or Tow				
Hospitel	within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	Check only 2 Medical Exe	hysicien: To the b	is of examina	owledge, deat ation and/or in	h occurred vestigation,	at the tin	ne, date an pinion, dea	d place, a	and due to the c	ause(s) and ate and pla	d manner as	stated.	s)
o the	ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manne			290	. Licens	e number		3	9d. Date si	gned (Mont)	h, Day, Year)	
To	ક⊨ં ઇ) muit	non.	110	1 10	2	14	1111-)		(.	24.	05	
			30. Name and address of person who	completed cause	of death (Iter	TI 23a) (Type	Print)	0	. , 00	,		•	- 0		
1-7+1			Michael McC	or neck	1111	10 M	edica	1	ange	15	lotaser	Mu	~ M	0 21	742
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 28	2005	gistrar's Signa	B. D	rese				lotager				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NZ U 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** PM /Medical June 25 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NU15,19 and Rehabilitation Center Berlin Worceste 11,1 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 97 Director 480 72 9379 Aug. 18, 1907 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 1 Meadow St. Gull Creek Retirement 21811 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3√ Widowed 4 □ Divorced "naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 10 Carmen Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Lindsey Elsie James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a David C. Lamb 9 June Way Lane Ocean Pines, MD Lamb, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) njury or permit. Page Department of Importent: If any injury or once. Cape Henlopen Crem. 6/27/05 Frankford, DE 108 William St. Service License 21. Signature) f Jung 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD 21811 23a. Part1. Enter the disease or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Eist only one cause on each line. Approximate Interval Between Onset and Death Priysician disease or condition resulting in death) 10 ailure Morths /Medical **Examiner** suspected to be mass carce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Completed by Physician/Medical Examiner Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Hanknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed 1 Yes 2₽No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☐ ₩o 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 2 No death. 1 Yes 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide n 24 hours a filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 COE 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

isting

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

COASTAL HIGHE

1209

32. Restrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician GHANSHYAM** DAS MANIYAR JUNE 24, 2005 3:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY 13109 MILLHAVEN PL. APT. C GERMANTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1**▼**M 2□F Hours Director 114-48-3137 65 AUG. 11, 1939 INDIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Items 23s or 28a-1 show any injury or other traumatic event, the Medical Exemine traust be inclified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1**X** Yes 2 □ No MD. MONTGOMERY **GERMANTOWN** Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13109 MILLHAVEN PL. #C 20874 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced ASIAN INDIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 PROJECT ENGINEER PECHTEL POWER CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KRISHNA **MANIYAR** 2 RAM SARSWATT CHANDUCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANOJ MANIYAR/SON 2272 PINE FOREST CT., LAS VEGAS, NV. 89134 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State
4 Donation 5 Other (Specify) CHAMBERS CREMATORY | 6-25-2005 RIVERDALE, MD. 21. Signature of Fyneral Service Lightnee 22. Name and Address of Pacility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC ADENOCARCINOMA OF THE COLON 8 MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached been signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown DEEP VEIN THROMBOSIS Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2**X** No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D35192 JUNE 24, 2005 30. Name an a dress of perso who complet cause o eath (Item 23a) (Type, Print) GILL, M.D. 14816 PHYSICIANS LA. #253, ROCKVILLE, MD. 20850 KEVIN 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

			1 - For State Registrer	State of Maryland /			of Health a		ental Hy	-	005	22728
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) Walter J. McDonald						2. Date of De Month June 2	1 20	05	3. Time of Death 4:03 P M
	Examir	er	4a. Fecility Name (If not institution, give single Shady Grove Advented Stroke Social Security Number 6. Sex	ist Hospital	irthday)		own, or Location of ville Year If Under		8. Date of Bi	Mon	county of Death	
	Funeral Director			M 2□ F 78	Yrs.	Months			12/21/	1926	New	York
	e Marylan Be-f show Illied at	ctor	10a. State 10b. County MD Montgomer	y German								10d. Inside City Limits 1 ☐ Yes 2X No
	th with th 23e or 28 ust be no	Funeral Director	10e. Street and Number 18818 Bent Willow	Circle, #413		10f. Zip 0				-	en of What Cou	ntry?
036	ours after des al', or Items Examinar m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 □ No If Yes, Give Year or Dates: WWII		Vas Decede Yes, specif	int of Hispanic Ori fy Cuban, Mexican No Specify:		cify Yes or N Rican, etc.)		4. Race - Ameri Black, White, Specify: Bla	, etc.
21215-0036	tiled within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23e or 28e-f show that the Mcdical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. [kind of work OO NOT use	Occupation done during mos retired)		ng	100	d of Business/Ir	
Maryland 2	ould be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Hugh McDonald						(First, Middle ne Hen		Sumame)	
e, Mar	l and 2 sho lealth and m 27 ls ma her trauma		19a. Informant's Name/Relationship (Typ. Sharon Davies - Fr	iend 86	80 W	les1ey	Street and Number	, #10	05, Fo	rt My	ers, FL	33919
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injurgo other traumatic event, the Michael Examinational De notified at once.		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Planetal Service License	Ft. Li	nco1	n Cre	matory 0	6/27 y Sim	ple Tr	Bren ibute		Maryland
	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do	not ente						, maryia	Approximate Interval Between Onset and Death Acaa
8760,	icate be executed physician and physician and sthe burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispose of Injury that initiated events resulting in death) Last	Due to (or as a consequence								
.O. Box 6	death certif e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pre				2:	3d. Date of delive	ery Day Year
rds, P	sign sign d be	þ	Part II. Other significant conditions con	tributing to death but not resulting	in the ur	nderlying car	use given in Part I			tobacco us Yes 2□	_	he cause of death?
Vital Record	The ate h	e Completed	25. Was case referred to medical					_	1 ☐ Yes	psy ormed2 No	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
of	ding Phys h. After this funeral dii	To B	examiner?	ospital: 1 Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year) 28b	Outpatien . Time of Injury		Other	ırsing Hon 2	Check on ne 5 ☐ Res 28d. Describe	idence 6	Other (Special occurred	5)
Division	Dire	Certification;	3 Suicide 6 Could not be 4 Hornicide determined	28e. Place of Injury - At home, building, etc. (Specify)				4	City or To	wn, State)		al Route Number,
	To the Hospital within 24 hours and To the Funeral completely filled	Medical	one) /2 Medical Exemin	ician: To the best of my knowled ler: On the basis of examination a and manner stated.	ge, death and/or inv	estigation, i	in my opinion, dea	nd place, a oth occurre	and due to the	date and	place, and due to	o the cause(s)
	15+1	-	29b. Signature and title of certifier Butt 92	z MB			License number	20			signed (Month,	2005
			30. Name and address of person who countries Brett Gamma MD, 99 31. Date filed (Month, Day, Year)	01 Medical Cent	er D	rive,		1e, M	farylar	nd 208	850	
	Sta Regista		88888	32. Redistrar's Signature	1	DE VE	•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 9:25 a M June Carr Morgan June 22, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3207 McComas Avenue Montgomery Kensington 8. Date of Birth (Month, Day, Year) ff Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 ☐ ¥F Yrs. 219-14-5110 85 June 1, **Director** Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Erand at must be nytified at 1 ☐ Yes 2 No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3207 McComas Avenue 20895 USA or itama 23a death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 257 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 School Teacher Education othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Carr ္ Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Morgan/ Husband 3207 McComas Avenue, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □Burial 2 □ Cremation 3 □ Removal from State June 27 Parklawn Memorial Park 4 □ Donation = 5 □ Other (Specify) 2005 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis Adress Collins Funeral Home Inc Kein Stile 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Type II Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examine The law requires that the death certificate be executed burial-transit Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the t IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetaf death 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe Alzheimer's Disease 1 Tyes 2√ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2X No fo the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) ပ 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Oescribe how injury occurred Certification: After Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No hours after death. M 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerei Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D48200 June 23, 2005 NI 30. Name and addr of of person who completed cause of death (Item 23a) (Type, Print) Alec M. Anders, M.D. 10400 Connecticut Avenue, Kensington, MD 20895 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 27 2005 12800 Registrar

			1 - For State Registrar		State of	Marylar	•	artmen rtificate			and M	lental Hy	giene Reg. 19		. 2	2730
	Physici		1. Decedent's Name (First, Mid MATTHEW		HASE		ME	ELSO	N			2. Date of De Month	Da	y Ye	ar 005	Time of Death
A	/Medic Examir	4.	4a. Facility Name (If not instituti	on, give s	treet and numb	per), /		4b. City,	Town, or	Location of	of Death			. County of [
¥.1			The Johns A	400	KINS.	HOSF	, HAL	BA	1/4	mor	RE I	1:40	/	Balti	more	
	Funeral Director		5. Social Security Number 221-90-5704	6. Sex			last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4-3-19	th 1y Year, 98	9.	Birthplace Country)	Md .
	and		Usual Residence of Decedent 10a. State 10b. Coun	v		10c, C	ity, Town or L	ocation							10d	Inside City Limits
	danyl f sho	ō	De. Suss	ev			lmar									1 □Yes ¾□No
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	ms 2:	Funeral Director	11. Marital Status	1	2. Was Deced	ent Ever in U	J.S. 13.	Was Deced	lent of H	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - /	American	ndian,
က္	or Ite	Fur	1 X Never Married 2 M	rried	Armed Ford	. Mo						Rican, etc.)		Black, V	White, etc.	
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21	ofthin Jen.	npi	Elementary/Secondary (0-12		College (1-	4or 5+)		kind of wor DO NOT us	e retired	1)		9				-
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and	be ti	Be	17. Father's Name (First, Middle		Taa							e (First, Middle		,		
7	should nd Men marke umatic	To	Charles W. Mel				401 14 11		10			eather				
Maryland	d 2 sk		19a. Informant's Name/Relatio Charles W. Mel			ather						De. 19		or Iown, Sta	te, Zip Co	de)
	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hydrene. Important: If item 27 is marked other than "neturel", or items 23s or 28e-1 show any njury or other treumatic event. If a Madical Examination will be notified at once.		20a. Method of Disposition	.5011,	51.	20b.	Place of Disp	nsition (Nan	ne of			Date		ocation - Cit	v or Town	State
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量	it. Purtani		* 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service			L1	ne Cem		d Addres	1	-25-			lmar,	Md.	
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Division of Vital Records,	quires n sign	d b		-	None -							10	Yes 2	10 3 E	Probably	4 □Unknown
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ta	ician: Th certiticate rector, pag	a	25. Was case referred to medi	al						26. Place	of Deat	1 ☐ Yes	2 N	0 10	103 20	140
f V	Physician: this certitics ral director,	To B	examiner?	Н	ospital:	patient 2	ER/Outpatie	nt 3 DO)A Oth	0.0		me 5 Resi		6 ☐Other (Specify)	
0	D te e		27. Manner of Death 1 □Natural 5 □ Pen	ting	28a. Date of (Month		28b. Time o	of 2	8c. Injun	y at k?	/	28d. Describe	how inju	ury occurred	A 4	
Si O	Attending r death. sctor: Atter	atic	2 Accident inve	stigation	June 1		un	M		Yes 2	No	Osser	ger	m	book	M.V.M. m
Ë	r Att ter de irect	Certification:	3 Suicide 6 Cou 4 Homicide dete	mined	28e. Place of building	of Injury - At I g, etc. (Spec	nome, farm,	reet, factory	, office	.10		28f. Location (City of To	Street a	nd Number (or Rural R	oute Number
	rat D							OA	d/	N 14	4	Douto	54	a Ma	4.32	3 M.d.
	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fun	edical	29a. Certifier 18 Certifier (Check only one)	ring Phys al Examir	ician: To the base. Ter: On the base and manner.	sis of examin	owledge, dea ation and/or in	th occurred ovestigation,	at the tin , in my o	ne, date an pinion, dea	nd place, ith occur	and due to the red at the time,	cause(s date an	s) and manne nd place, and	er as state due to the	d. cause(s)
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	B		30. Name and address of pers				m 23a) (Type	. Print)								
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			1 - For State Registrar	State of Maryland		rtment of F				jiene	005	22731
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	Funeral Director		5. Social Security Number 6. Sex 158 - 01 - 1091	Wisked Live 7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under	er 34 Hrs. 8.	Date of Birth (Month, Day	Year)	9. Bir New	thplace (State or Foreign Durity) Jersey
	the Maryland 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	10c. City,	Town or Loc	R			/ /			10d. Inside City Limits
36	72 hours after death with the Maryland natural', or itama 23a or 28a-1 show Jisol Examitrer riust be notified at	by Funeral Dir	11. Marital Status 12. 1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) If Yes, Give	If	/as Decedent of H Yes, specify Cubi	dispanic C an, Mexic			45	4. Race - Ame Black, White	erican Indian,
21215-0036	within liene. r than "	Completed b	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12	Year or Dates: tion completed) College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retired	during mo	ost of working		16b. Kin	d of Business	•
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Baltimore, Ma	es 1 and 2 of Health a f Item 27 is r other tra		Judy Myers/Guardia 20a. Method of Disposition 1 □ Burial 2 🖫 Cremation 3 □ Rem	20b. Pla	2771. ace of Dispos metery, crem	Address (Street Pember ition (Name of atory or other place	ton 1		alisbu	ry, N	4D 2180 ation - City or	Town, State
Baltir	permit. Pag Department Important: i any injury o	2	'4 □ Donation 5 □ Other (Specify) 21 Structure → Funeral Service Licensee	mosos CF	#G SP 50	UI SHOW.	ss of Fac Fune: Hill	ral Hom	e Proj	fessi ry,	isbury, ional <i>R</i> MD 218	Association
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	ding Phys h. After this funeral dii	To B	25. Was case referred to medical examiner? 1 Yes 2 No Hos 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 IE	R/Outpatient 8b. Time of Injury	28c. Injur	er: 4□N vat	28d		ence 6		LIVING FAULTY
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	Car	••	30. Name and address of person who comp D.R. U.S.HA NATES AT 31. Date filed (Month, Day, Year)	N. 1145- S. D	hasand	\$7	SALIS	BURY	MDZIS	04		
	Sta Registr		31. Date filed (Month, Day Year) 7 20	05 Aleen	H A	book						

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Physicia /Medica	n al	1. Decedent's Name (First, Middle, Last Lisa Christine	Marrion				2. Date of De Month June	27, 200	
Examine		4a. Facility Name (If not institution, give 39146 Middleton La 5. Social Security Number 6. Se	ine	n yrs. last birthday)	4b. City, Town, or Clements If Under 1 Year	Location of Death		St.	Mary's 9. Birthplace (State or F
Funeral Director			□м ЖР	39 Yrs.	Months Days	Hours Min.	8. Date of Bi 8-3-19	Year)	Washington,
a-f sho	, L	Maryland St. Ma	_	Clements					1 ☐ Yes 2
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent. It we Widical Examination in Millied at	by Funeral	39146 Middleton L 11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give	1	20624 Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 No		pecify Yes or No Rican, etc.)		ace - American Indian, lack, White, etc.
vithin 72 hours ne. han "natural" v Medical Ex.	Completed b	3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates: ucation de completed) College (1-4or 5+)	16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wor	king	16b. Kind of	Business/Industry
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t. Page rtment or rtant: If njury or	1	1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens)	Queen of	Peace cem	i. July			n, Maryland
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	edical	29a. Certifier (Check only one) 1☐ Certifying Phy 2☑ Medical Exam	rsicien: To the best of m iner: On the basis of ex and manner stated	amination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and n date and place	manner as stated. e, and due to the cause(s)
To I To I	Σ	29b. Signature and title of certifier			29c. License OCM				ned (Month, Day, Year) 28, 2005
		Yumin Jouth	all, ms						iaryland 2120

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			1 - State Registrar		-	rtificate of			2005	22733
П	Physicia	an	1. Decedent's Name (First, Middle, Last)		-			Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Helen Annie Lee M			T		06 - 21	- 2005	18:55 p M
	Examin	er	4a. Facility Name (If not institution, give s Holy Cross Hospita			Silver	or Location of Death		4c. County of Deat Montgon	
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
п	Director		3/9-32-1111	M 2021F	67 Yrs.	Months Days	Hours Min.	01-03-19		ence, Ala.
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	th the or 28a e roll	Director	10e. Street and Number	· J	33221132	10f. Zip Code		10g.	Citizen of What Co	untry?
	23a c		112 Duvall Lane			20	877		U.S.A	
	er dea	Funeral		12. Was Decedent 8 Armed Forces? 1 □ Yes 2 🛣	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spectar), Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
36	irs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	40	1□Yes 2X No	Specify:		Specify: B	lack
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or Itams 23s or 28s-f show event, I're Medical Exertiner must be notified at		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation	168	o. Kind of Business/	Industry
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and	d be f antal h ced of	o Be	Alfred King				18. Mother's Name Eva Mae H		aen Sumame)	
ary	2 should be and Mental is marked o	은	19a. Informant's Name/Relationship (Type	pe, Print)	J9þ-Maiji	ng Address (Stree	tand Number or Rural		ity or Town, State, 2	Zip Code)
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Вох	death certifica e attending ph id for use as th	Physician/Med	200. Was decedent pregnant	3c. If yes, outcome 1 Live birth		⊒Ectopic pregnanc	ev		23d. Date of del	*
В	Ø 0 0	/sici	in the past 12 months? 1 □ Yes 2 🌠 No 9 □ Unknown	4□Pregnant at 9□Unknown		Other (specify)	·1		Month	Day Year
<u>α</u>	law requires that the de as baan signed by the a 2 should be detachad f		Part II. Other significant conditions cor	ntributing to death be	ut not resulting in the u	ınderiving çause gi	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	uires tha signed Id be de	d by	Hypertension	•		J. J				obably 4 Unknown
CO	tw requir	lete	Osteomyelitis					24a. Was an	24b. Were au	topsy findings available
Re	8 - 9	Completed						autopsy performed	prior to o	completion of cause of
Vital	l cian : Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death		140 12163	2,4,1110
7	Physician: this certific ral director,	은	1 ☐ Yes 2X No	fospital: 1 🔀 Inpatie		nt 3□ DOA Ot	her: 4 \(\sum \) Nursing Hom			cify)
Division of	ding J. After fune	ion:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year) 28b. Time o	Wo	nyat 2: ork?]Yes 2 ∐No	Bd. Describe how i	injury occurred	
/isi	ten lea tor the	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, st			8f. Location (Stree	t and Number or Ru	ıral Route Number
Ö	al or /	Certification:	4 Homicide determined	building, etc	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, S	îtate)	
	Hospital or 24 hours afte Funerel Dir stely filled in I	ical (29a. Certifier Certifying Physical Check only 2 Medical Examin	sician: To the best of	of my knowledge, dear	th occurred at the ti	ime, date and place, a	nd due to the caus	e(s) and manner as	stated.
	the the the	Medi		and manner sta	ited.		opinion, death occurre			
	or Too	~	29b. Signature and title of certifier	HAM	M	29c. Licen:			Date signed (Monti	
. 4	10		30. Name and address of person who co	moleted cause of d	eath (Item 22a) (Time				ne 22, 200	
X	- (1)		Shahid Shamim, MD	ampleted cause of 0	оані (попі 23 2) (Туре.		Forest Glo er Spring,		1, 20910	
	Sta		31. Date filed (Month, Day, Year)	2. Registra	ar's Signature	A.	1 3 9		_,,	
	Registr	ar	JUN 2 8 2005	Plone	A KON					

WILLIAM McKinney

	•	For State		State of M	aryland / I	Department of Certificate o		ivientai ny	giene	000	00701
		Registrar	ne (First, Middle, La	et)		Oortmeate o	Death	2. Date of D	eath	005	234
ysicia Tedic			illiam	т.	Mc	Kinney		Month JUNE	Day	Year 2005	3.29 A ^M
amin		4a. Facility Name	(If not institution, giv	e street and number))	4b. City, Town	, or Location of Dea	ath	4c. C	ounty of Death	1
			A MEDICAL				PLATA			CHARLE	S
eral		5. Social Security		IDM SDE	ge (In yrs. last bii	rthday) If Under 1 Year Months Day		(Month D	av. Year)	LOI	nplace (State or Foreignatry)
ctor		139-34-(Usual Residence	J412	X	60	113.		Novemb	er 25	Sou	th Carolin
4		10a. State	10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
other freumatic event, it a Medical Examinat must be notified at	by Funeral Director	MD	Charles			Waldorf					1 X Yes 2 No
SE LIC	Dire	10e. Street and No				10f. Zip Code) -	en of What Co	untry?
373	ra .		Oornock Co			2060				S.A.	
Jan 1	nue	11. Marital Status		12. Was Decedent Armed Forces	?	13. Was Decedent of If Yes, specify C	if Hispanic Origin? (uban, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0- 14	 Race - Amer Black, White 	
Na Car	y F		rried 2 Married 4 □ Divorced	If Yes, Give Year or Dates:	No Navy	1 ☐ Yes 2 🕱 N	lo Specify:		5	Specify: B1	ack
4			15. Decedent's E		16a	. Decedent's Usual Occ	cupation		16b. Kind	d of Business/l	ndustry
N N	Completed		cify only highest gra	ade completed)		(Give kind of work doi life. DO NOT use ret	ne during most of w	orking			
100	mo	Elementary/Sec	ondary (U-12)	College (1-4or	3+)	Manager			Go	vernme	nt
/ent,	a	17. Father's Name	(First, Middle, Last)			18. Mother's N	ame (First, Middle	a, Maiden S	Surname)	
tic e	To B	John M	ack McKin	ney			E11a	Watson			
n ma		19a. Informant's I	Name/Relationship ((Type, Print)	198	o. Mailing Address (Stre	et and Number or I	Rural Route Numi	per, City or	Town, State, Z	ip Code)
er tre		Deloris	McKinne	y/Wife	12	2134 Dornoc	k Ct. Wal	dorf, Ma	rylan	d 2060	2
any injury or other once.		20a. Method of Di	•		comete	of Disposition (Name of	olace)	Date	20c. Loca	ation - City or	Town, State
5			Cremation 3 ☐ 5 ☐ Other (Specil	□Removal from State fy)	•	Lawn Cemete	1	30/05	Fairl	lawn Ne	w Jersey
n e		21. Sign dure of	un al Service Lice	nsee			dress of Facility				
any ir				\rightarrow			dover Roa				
ner											
	i Examine	Sequentially list of any, leading to it cause. Enter Unc Cause (Unsease of that initiated even resulting in death)	ts	c	s a consequence						
מכוופן וטו מפר מס נוופ מתוומן וו מווסור	hysician/Medical	that initiated even	nt pregnant 2 months?	Due to (or as Due to (or as d. 23c. If yes, outcome	s a consequence	of):			23	3d. Date of deli Month	very Day Year
	by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	int pregnant 2 months?	Due to (or as C	s a consequence of pregnancy Testal death t time of death	of): 3 ⊟Ectopic pregna			tobacco us	Month e contribute to	Day Year the cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	Reg.			·	
	Reg. Mg	. U	U	· J	

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/M	lec	lic	al
Exa	am	in	er
Exa	am	in	er

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination and be notified at once.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

MCNEIL PATRICIA, 6/21/05, 12.05pm

State Registrar

an	PATRICA	_231/	ANN	ſ	MCNEII	T			Month JUNE	Day 21	200		12:05	m M
cal ier	4a. Facility Name (If not institution, g	ive street and n					r Location	of Death	JUNE		ounty of E		12:05	<u>. r</u>
	SUBURBAN HOSPIT	[AL			ROC	KVIL	LE			MON	TGOM	ERY	,	
	Social Security Number 6.	. Sex	7. Age (II	n yrs. last birth		r 1 Year	If Under	r 24 Hrs. Min.	8. Date of Birt (Month, Day				ace (State	or Foreign
	203-34-8389	1 □ M 2 🟋	62	Yı	rs.	Days	riouis	IVIII I.	Novembe					ROLINA
	Usual Residence of Decedent 10a, State 10b, County		10	o City Tour	1									
_	10a. State 10b. County		10	c. City, Town	or Location							10	Od. Inside C	
ctc	MD MONTGON	TERY		SILVER										s 2 🗌 No
ä	10e. Street and Number					p Code				10g. Citizer		Count	try?	
<u>a</u>	1545 IVYSTONE C					0904					S.A.			
nue	11. Marital Status	12. Was Dec	orces?	r in U.S.	13. Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Or an, Mexica	rigin? (Sp in, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - A Black, V		an Indian, etc.	
Y.	1 X Never Married 2 Married 3 Widowed 4 Divorced	f Yes, G Year or	2 XNo		1 🗆 Yes	2 X No	Specify	:		Sp	ecify:	ВŢ	ACK	
Completed by Funeral Director	15. Decedent's		Dates:	162 [Decedent's Usu	ial Occur	ation			16h Kind	of Busine			
jet	(Specify only highest of)	(Give kind of w	ork done	durina mos	st of work	ing	16b. Kind	or Busine	ess/ina	ustry	
III C	Elementary/Secondary (0-12)	College 2 yrs	(1-4or 5+)		TAL CLI		-/			GOV	ERNM	ŒNI	1	
	17. Father's Name (First, Middle, La						18. Moth	er's Nam	e (First, Middle,	Maiden Su	mame)			
To Be	SIMUEL MCNEILL						RO	SETT	A MCNEI	LL				
-	19a. Informant's Name/Relationship	(Type, Print)		19b. I	Mailing Addres	s (Street	and Numb	er or Rur	al Route Numbe	r. City or To	own. Stat	e. Zio	Code)	
	MONICA J. HARRIS	SON/DAUG	HTER	15	45 IVY	STONE	COU	RT S	ILVER SE	RING,	MAR	RYLA	ND 20)904
	20a. Method of Disposition		12	20b. Place of D	Disposition (Na	me of	1		Date	20c. Locat	tion - City	or Tov	wn, State	
	1 X Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Special Control		State	-	. crematory`or F HEAVI			6/30	/05	SILVE	R SP	RTN	IG_MAR	TVA.TYS
	21. Signature of Funeral Service Lice			GAIL O.	-		1		B. JENK				_	
	1 X N	1.000							LANDOVE					
	23a. Part1. Enter the disease, or co	emplications that	caused the	death. Do no									Approxima	
	shock, or heart failure. List on Immediate Cause (Final			TON DN	TID (ANT								Interval Be Onset and	
ĺ	disease or condition resulting in death)	a		TION PN		Α.								
				onsequence of AL INFA								,		
ē	Sequentially list conditions,	D.		onsequence of										
i	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1			•									
xai	that initiated events resulting in death) Last	c Due to	(or as a co	onsequence of):									
jai														
sician/Medical Examiner		G												
N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of p	regnancy						23d	. Date of	deliver	v	
cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	nant at tim	Fetal death e of death	3 ∐Ectopic p 5 ☐ Other (s						Month		-	Year
Phys	9 Unknown	9□ Unk	nown											
by PI	Part II. Other significant conditions	s contributing to	death but n	ot resulting in t	he underlying	cause giv	en in Part	1.	23e. Did to	bacco use	contribut	e to the	cause of	death?
b b									1 🗆 Y	es 2 🗆 N	io 3 🗆	Proba	ibly 4 🕱	Unknown
Completed									24a. Was a	an 2	4b. Were	auton	sv findings	available
Ĕ									autop: perfor	med?	deatr	17	sy findings ipletion of c	cause of
C	25. Was case referred to medical						OF Dise	a of Doot		2 X No	1 🗆 \	95 2	No No	
m	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	2 ER/Outp	atient 3 D	OA Oth	OF:		h (Check only or ome 5 - Resid		Other (C		-	5.0
.: To	27. Manner of Death	28a. Date	of Injury	28b. Tir	me of	28c. Injur	v at		28d. Describe h			респу		
tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		nth, Day Ye	ea <i>r)</i> Inji	ury M	Wor	k? Yes 2. ☐	No						
fica	3 Suicide 6 Could not	t be 28e. Plac	e of Injury	- At home, farn	n, street, factor	v. office			28f. Location (S		umber or	Rurai	Route Nun	nber.
Certification:	4 Homicide	buile	ding, etc. (5	specify)					City or Tow	n, State)				
ai C	29a. Certifier 1 Certifying	Physician: To th	e best of m	ny knowledge,	death occurred	at the tin	ne, date ar	nd place,	and due to the o	ause(s) and	d manner	as sta	ited.	
Medical	(Check only 2 Medical Ex	aminer: On the	basis of ex nner stated	amination and/	or investigation	n, in my o	pinion, dea	ath occur	red at the time, o	ate and pla	ice, and	due to	the cause(s	5)
Me	29b. Signature and title of certifier				29	c. Licens	e number		2	29d. Date s	igned (Mo	onth, D	ay, Year)	
	► UMM				1	00061	302			June	22,	20	05	
	30. Name and address of person wh	no completed car	use of death	n (Item 23a) (T	ype, Print)									
	ATUL ROHATGI	M.D. 80	600 OI	LD GEOR	GETOWN	ROAI	BET	HESDA	A, MARYI	AND 2	0814			

DHMH 17 Rev 1/2001

JUN 2 8 2005

		For State Registrar	State of Maryland	d / Depa		nt of H	ealth and	Mental Hy		9	2273
Physicia /Medica	al -		ARTENY					2. Date of De TMonth	aath Da	2005	4.35 0
Examine	er	4a. Facility Name (If not institution, give Doctor's Communit				, Town, or anham	Location of Deat	h		ince Ge	
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	ast birthday)	If Unde	r 1 Year	If Under 24 Hrs	8. Date of Bir	Ť		thplace (State or Fore
Director		216-58-8365 Usual Residence of Decedent	53 ≤ 53	Yrs.	Months	Days	Hours Min.	8. Date of Bir (Month, Da Mar. 2	, 19	52 Was	hington, D
5-0036 72 hours after death with the Maryland natural; or terms 23a or 28a-f show often Enatural te rediffed at	Director	MD Prince G	_	Town or Lo	ocation						10d. Inside City Lin
with th		10e. Street and Number				p Code			10g. Ci	tizen of What C	
ms 23	era	8623 Park Avenue	12. Was Decedent Ever in U.S	S. 13.		0720 Ident of Hi	spanic Origin? (S	pecify Yes or No	D-	U.S.A.	erican Indian,
urs after all, or Item	by Fur	1 Never Married 2X Marned 3 Widowed 4 Divorced	Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates:	- 1	If Yes, spe 1 ☐ Yes		Specify:	o Rican, etc.)		Black, Whi Specify:	te, etc. Thite
	Completed by Funeral	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done o use retired	ttion luring most of wo	rking	16b. K	(ind of Business	
C Z C	် ပ	12		Cons	truci	tion	Worker	1000 11111		onstruc	tion
Iryland 212 should be filed within and Mental Hygiene. marked other than matic event, It a Market	2 Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar The 1 ma			n Sumame)	
Maryland d 2 should be fill th and Mental Hy 7 Is marked ah traumatic even	2	Howard Turner 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili	ng Addres	s (Street 2	and Number or Ru			or Town, State,	Zip Code)
G, MG 1 and 2 Health a Health a Health a Health a Health a		Vicci Marteny, Sp	ouse	8623	Parl	k Ave	nue, Bov	ie, Mar	y1an	d 2072	.0
Baltimore, IV permit. Pages 1 and Deportment of Health Important: If item 27 any injury or other ir	-1	20a. Method of Disposition 1 ☐ Burial /2X Cremation 3 ☐ I		ace of Dispo metery, crea	osition (Na matory or	me of other place	9)	Date	20c. L	ocation - City or	Town, State
Baltimor permit. Pages Deportment of Important: If it any injury or o		 4 □ Donation 5 □ Other (Specify, 21. Signature of Furieral Service Licens 	ILICEL	opolita			s of Facility Ga	01/2005			a, Virgini
Departit. Departitimports any nig	Į	21. Signature of Professional Service Liberts									Maryland
Physician		23a. Pant Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications hat caused the death ne cause on each line.	. Do not ent	ter the mo	de of dying	g, such as cardia	or respiratory a	rrest,	,,	Approximate Interval Between
/Medical Examiner		resulting in death)	a. Myo Due to (or as a consequence) b. Core	ence of):	· /	W 40	mi D.	" LEGGE			i'mredig Sym
peti usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	rence orj.	9 21	,,0	, y v .	10012			3 9.00
/ Sicial	cai Exa	that initiated events resulting in death) Last	Due to (or as a consequent	ence of):							
OT VITAL RECORDS, P.O. BOX 6870 Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the beautificated to the page 2 should be detached for use as the beautificated to the page 2 should be detached for use as the beautificated	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	⊒Ectopic p ⊒ Other (s _i					23d. Date of de Month	livery Day Year
uires that the signed by Id be detac	2	Part II. Other significant conditions co	intributing to death but not resu	lting in the u	inderlying (cause give	n in Part I.				o the cause of death?
VItal HECOrds, sician: The law requires t certificate has been signe frector, page 2 should be o	Completed							24a. Was auto perfo	psy ormed?	prior to death?	utopsy findings availa completion of cause
sician: T	0	25. Was case referred to medical					26. Place of Dea		2 <mark>⊈N</mark> o one	1 Yes	s 2□No
OT V	TO B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I	R/Outpatier	nt 3 🗆 D	OA Othe		lome 5 ☐ Resi		6 □Other (Spe	ocify)
ding After fune		27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f i	28c. Injury Work 1 🔲 Y	at ? ∕es 2 □ No	28d. Describe	how inju	ry occurred	
DIVISION tall or Attenders after death all Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, st	reet, factor	y, office		28f. Location (City or To			ural Route Number,
Hospi 24 hou Funer Rely fill	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred vestigation	at the tim	e, date and place inion, death occu	e, and due to the irred at the time,	cause(s date an) and manner as d place, and due	s stated. e to the cause(s)
To the within To the comple	2	29b. Signature and title of certifier Pave2	O Symite		entandro en ricigirala del	c. License	1757	2		te signed (Mont	05
·R(15)		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type,	Print)	m	eu bo	1+ 27	A 2	20770	?
		7, 0	7 7 -					(1)			

		1 - For Unpend Item 23a,27,28	Maryland/Depa a-1 per me Cel	adment of H 846 8 8 rtificate of l	lealth and I US tas Death			22737
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) Tyrone Eric McMullen 4a. Facility Name (If not institution, give street and number)	r)	4b. City, Town, or	Location of Death	2. Date of Deat Month JULY	Day Year 5, 2005	3. Time of Death 9:02A. M
, Funeral Director		37 LEEDLE CIRCLE 5. Social Security Number 212-50-3639 6. Sex 1 □ XM 2 □ F	Age (In yrs. last birthday) 58 Yrs.	RISING If Under 1 Year Months Days	SUN If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Voar Co	nplace (State or Foreign untry)
D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			June 1,	1947	10d. Inside City Limits
with the M 3a or 28a-f	Funeral Director	MD Cecil 10e. Street and Number 37 Leedle Circle	Rising.	10f. Zip Code 21911		10	0g. Citizen of What Co	1 X Yes 2 No untry?
d within 72 hours after deeth with the Maryland jene. jene. r than "naturel", or Iteme 23a or 28a-f ehow	b	11. Marital Status 12. Was Deceder Armed Force: 1 Never Married 2 Married 1 X Yes 2 □	: 1965-69	Was Decedeni of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	
within iene. than	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o 1 2 17. Father's Name (First, Middle, Last)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	Railroa	,
2 should be filed and Mental Hyg le marked other aumatic event,	To Be	Vernon E. McMullen 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	Margar	et E. Ty	,	iip Code)
. a è E E		Dawne D. McMullen/sister 20a. Method of Disposition 1 💆 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo	oring Hou pation (Name of matory or other place			un, MD 219 20c. Location - City or	
permit. Pages 1 ar Department of Hee Important: If Item eny injury or other once.		4 Donation 5 Other (Specify) 21. Signatuse of Funeral Service Licensee	West Not	tingham C 2. Name and Addres 11 S. Que	ss of Facility R.	T. Foard	<u>Colora, Mar</u> Funeral Ho In, MD 219	me, P.A.
Physician		23a. Part1. Enter the disease, or complications that caus shock or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) . Narcoti		ter the mode of dyin				Approximate Interval Between Onset and Death
death certificate be executed e attending physicien and defor use as the burial-transit	ilcai Examiner	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):					
death certific e attending p	Physician/Med		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very . Day Year
w requires that the been signed by the should be detache	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		pacco use contribute to	the cause of death?
The ta ete has page 2	e Completed	25. Was case referred to medical					y prior to death? Oned? death?	topsy findings available completion of cause of
Phy raid	To B	examiner? 1 \text{Yes} 2 \text{No} \text{No Hospital: } 1 \text{ lnpa} 27. Manner of Death 1 \text{Natural} 5 \text{ Pending} 2 \text{Accident} investigation Policy Policy	Day Year) 28b. Time o	f 28c. Injury Work	er: 4 ☐ Nursing H		nce 6 Xother (Spec	unk
or All fler direct	Certification:	3 Suicide 6 To Could not be 4 Homicide 28e. Place of building, residen		reet, factory, office		Rising S	reet and Number or Ru , State) 37 Leed Sun, Maryla	ie Circle nd
To the Hospital or Al within 24 hours efter of To the Funeral Direct completely filled in by	Aedicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the be 2 ☐ Medical Examiner: On the basis and manner	of examination and/or in	vestigation, in my of	pinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
To with	×	29b. Signature and title of certifier	our &	29c. License OCI			od. Date signed (Monti	
		30. Name and address of person who completed cause of HEDPORE M. Kerf	dath (Item 23a) (Type,	111 J	Penn Stre		•	yland 21201
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	w .				

			1 - State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F		-	giene Reg. 2005	22738
	Physici		1. Decedent's Name (First, Middle, Last)	Mou	gers	-		2. Date of Dea Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s		70.00	4b. City, Town, o	r Location of De	eath	4c. County of De	ath
			Sylvesuille	Eldo	, care	SYKESV				RROLL
	Funeral Director		5. Social Security Number 6. Sex XX	M 2□F	(In yrs. last birthday 79 Yrs.	Months Days	Hours N	lin. 8. Date of Birt (Month, Da AUGUS'	9. Bi	rthplace (State or Foreign Country) MARYLAND
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Manyla 1 sho	ţo	MARYLAND CARROL		SYKESV					1 Types 2 No
	or 28e	Director	10e. Street and Number	WWW.TTT.		10f. Zip Code			10g. Citizen of What C	country?
	ath wi		CONTINUUM CARE AT S 7309 SECOND AVENUE			2178			UNITED S	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Importents if Item 27 is marked other than "natural", or Items 23a or 28e-f show my injury or other treumatic event, if a Madical Examinal translate notified at ances.	by Funeral	11. Marital Status XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 Was Decedent E Amed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates: 		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXXIIIO	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No verto Rican, etc.)	Black, Wh	
2-00	2 hou		15. Decedent's Educ	ation	16a. Dece	edent's Usual Occup	pation		16b. Kind of Busines	
21215-0036	ithin 7 ne. "ner ne Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+) (Give	e kind of work done DO NOT use retired		working		
	filed w Hygier other th	e Cor	17. Father's Name (First, Middle, Last)			DISABLE		Name (First, Middle,	N/A	
Maryland	Mental Mental rked o	m	VILBUR MAGERS					IE BURDET		
lary	2 should and Men is marke eumatic	, s	19a. Informant's Name/Relationship (Ty)						er, City or Town, State,	Zip Code)
	1 and Heelth em 27 ther tr		GAIL JONES/GUARDIA 20a. Method of Disposition	OF THE	20b. Place of Disp		AVENUE,	WESTMINST Date	PER, MD 21	157
mor	Pages nent of int: If its		1 ☐ Burial 2\(\sum_{\text{Cremation}}\) Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	CARROLL C	ematory`or other plac		24/2005		, MARYLAND
Baltimore,	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service License	e 1		2. Name and Addre	ss of Facility			, PARTIDAND
8	89 5 5 8	1	Janel (1. May	7	91 WILL	JRBORAW IS STREI	FUNERAL I	HOME, P.A.	21157
I			23a. Parri. Enter the disease, or complishock, or heart failure. List only or	e cause on each lin	the death. Do not er e.	nter the mode of dyir	ng, such as card	diac or respiratory ar	rrest,	21157 Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	2 heim -	6621	7,200	22		
	Examiner		Sequentially list conditions	324	or We	, wou	105	is lea	10112	
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	1 to it	· C. ·	es lea	11011	
ć.	execut n end ial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):	11 14 11	3 300	CNOO C	Jisa	
38760,	cate be executed physicien end the burial-transit	dicai		M	funls	81710	3			
a		Med	IF FEMALE:	2- 14						
Вох	death certifi e attending I id for use as	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of 1☐Live birth = 3 4☐Pregnant at	2 🗌 Fetal death 3	□Ectopic pregnancy	<i>f</i>		23d. Date of d Month	elivery Day Year
P.O.	that the death led by the atter detached for i	hysi	9 Unknown	9 Unknown						
	The law requires that the ste has been signed by the bage 2 should be detache	Completed by Physician/Me	Pan II. Other significant conditions cor	tributing to death bu	it not resulting in the	underlying cause giv	en in Part I.		obacco use contribute	to the cause of death? Probably 4 Dunknown
Records,	w requ	letec	6/25/100	1 01	200	<u> </u>		24a. Was		
Re	sicien: The law certificete has b irector, page 2 s	ошо	111101110	0/2)	diase	<u>``</u>		- autop	prior to death?	autopsy findings available completion of cause of
Vital	w	Be C	25. Was case referred to medical examiner?				-	1 Yes		5 2 10
of V	ding Physicien: h. After this certifica tuneral director,	မ	1 Yes 2 No	ospital:			4 Twursin		dence 6 Other (Sp	ecify)
lon	ding After fune	ıtlon	1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time (Year) Injury	Wor	yat rk? Yes 2 ∐No	280, Describe i	how injury occurred	
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	rry - At home, farm, s	treet, factory, office	,	28f. Location (S City or Tox	Street and Number or F vn. State)	Rural Route Number,
	pitel or ours afte erel Dir	Cer	One Contiliar III Contilian Bloom							
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	ician: To the best of ier: On the basis of and manner sta	examination and/or is	un occurred at the tir nvestigation, in my o	me, date and pl opinion, death o	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	is stated. se to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		٨.	29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
,	WSV		1 held 13	resp	-V-VL-	()(£ 17	3	61541	25
	1 /		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type	Print) Ko	12 3 C	Kraer W	EX, MP	W 2/208
	Sta Registi		31. Date filed (Month, Day Year) 2 7	2005 32. Regida	r's Signature	1			, , , , , ,	- 1.0100
-	ricgisti	aı	•		W.	LORAL				

ub/27/05 OK to Accept 23A per Jotce Hear

Amended Items 26 & 28c per Physician 06/23/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment of H rtificate of I			2005	22739
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	VID /	MEIN	IECKE	,		Day Year 70 2005	3. Time of Death 6:15 M
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Death	
	Funeral		CARROLL HOSPITA 5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year	INSTER If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	CARROL:	place (State or Foreign
	Director		210-30-4340	M 2□F 6	2 Yrs.	Months Days	Hours Min.	7/7/194		YLAND
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	MD CARROLL	W:	ESTMIN	NSTER				1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number	oc pp		10f. Zip Code	1 - 7		Citizen of What Con	intry?
	death ms 23	Funeral Director	1842 SNYDERSBUE	2. Was Decedent Ever in L		Was Decedent of H	157 ispanic Origin? (Spe	cify Yes or No-	SA 14. Race - Amer	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be multised at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		lf Yes, specify Cuba 1 ☐ Yes 2 🔯 No	n, Mexican, Puerto P	Rican, etc.)	Specify: WH	
15-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	ng 16t	o. Kind of Business/I	ndustry
2121	s withir jene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			" E MAKER	MZ	ANUFACTU	RING
g	al Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Mai	den Sumame)	
Maryland	nould b	To I		NRAD	MEINE				OTHY NO	
<u>s</u>	Ith and 2 shall the and 27 is r		19a. Informant's Name/Relationship (Type ROSE ANN MEINECH	•			and Number or Rura. SBURG RD			MD.21157
ore,	of Hea		20a Method of Disposition	20h	Place of Disno	sition (Name of	D	ate 200	. Location - City or	own, State
Baltimore,	tment tant: It		1X Burial 2 □ Cremation 3 □ R. (*4 □ Donation 5 □ Other (Specify)	MEAL	OOW BR	ANCH CE	M. 6/23	10.51	STMINSTE	
Bai	Departiment Departiment Departiment Department Departme		21 Signature Thornal Service License		2	54 E. M.	ss of Facility FLE AIN ST.,	WESTMIN	STER, MI	
ľ			23a. Pa 1. Enter the lisease, or complied shock, or hear failure. List only on	e cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	OR O/	VARY	ART	try Si	JEM JE		
8	Examiner		Sequentially list conditions, b	Due to (or as a conse	1100	BITRU	tour a	UNG C	MEANE	
	ed sit	ulner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):			0		
Ć,	execut in and ial-trar	Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):					
68760,	licate be executed physician and s the burial-transit	edical		•	· · · ·					
_	- 0	/Mec	IF FEMALE:	3c. If yes, outcome of pregn	nancv				22d Date of dali	
Box	The law requires that the death certi sie has been signed by the attending bage 2 should be delached for use a	Physician/M	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliment	Day Year
P. O.	hat the	Phy	9 ☐ Unknown Part II. Other significant conditions con		sulting in the u	nderbina cause aiv	en in Part I	23e Did tohac	co use contribute to	the cause of death?
Vital Records,	w requires been signe should be	ed by	•							bably 4 Unknown
eco	e law re has bee je 2 sho	Completed						24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of
a R	ystcian: The is certificate hadirector, page							performed	death? No 1 ☐ Yes	
Ĭ	s certificactor	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatier	nt 3□ DOA Oth	26. Place of Death er: 4 ☐ Nursing Hon	/	e (10ther/6000	76)
Division of	or Attending Physician: ufer death. Director; After this certifics in by the funeral director, p	H- 1	27. Manper of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	" 3D DON	4 Nursing Hon	8d. Describe how	6 ☐Other (Specinjury occurred)	(Y)
Siol	or Attending I after death. Director; After in by the funer	catlc	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 10 10 10			
Σ	affor At affer of Direct	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str vify)	reet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru itate)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physical Control one) 2 Medical Examination	ician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus and at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1 0 100	<u>-</u> -	29c. Licens		29d.	Date signed (Month	, Day, Year)
)	WIL		> solve	N CM			352		6/21/00	n1150
	ب ا		30. Name and address of person who co		m 23a) (Type,	Print)	ON ROAL	WE.	TMINSTE	R MD
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		- 14 1011-	5500	11110010	1- 1-
	Registr	ar	JUN 2 3 21	105 Elsen	K.	had,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month JUNE 20 2005 5:50 A^M MARGARET LILLIAN _ MCLEAN /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES 8605 BEL ALTON NEWTOWN RD. ALTON BEL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Hours Days Months 1 M 2 X F Director DEC.11,1921 NORTH 246-28-3750 83 CAROLIN Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinating must be notified at 1 ☐ Yes 2√ No Directo BEL ALTON MARYLAND CHARLES 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code U.S.A. NEWTOWN ROAD 20611 8605 BEL ALTON Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2√☐√No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Completed by WHITE \$₩Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. RESTAURANTS WAITRESS 1.2 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other you injury or other traumatic event 17. Father's Name (First, Middle, Last) Be ETHEL RAGAN FORACE MORETZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLAND 20646 P.O. BOX 2318, LA PLATA, EFFIE PHELPS-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) WOODLAWN CEMETERY 6-25-05 BLOWING ROCK, NC M00479 21. Signature of Feneral Service Licensee 22. Name and Address of Facility FUNERAL SERVICE, RAYMOND 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner and I-transit the death certificate be executed Due to (or as a consequence of): rsician a e burial-l the phys as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No
9 Unknown ō Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown been signated by the property of the property Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 25 2 🗀 No 1 Yes 1 Yes 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2010 Other: 1 🗌 Yes 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Sidence 6 ☐ Other (Specify) this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Dea 28a. Date of Injury (Month, Day Yeer) 28b. Time of Certification: After 1 the Hospital or Attending 1- Natural 5 Pending Injury 1 Tyes 2 No death. investigation 2 Accident Director: 3 Duicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire filled 29a. Certifier 🔟 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JUL 1 1 2005 Palistrar's Signature State Registrar

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Records,

Division of Vital

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		•	For State Registrar	, ,	•	tificate of l			eg. No	15	2271.1
	Dhusisi		Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
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			Washington County 5. Social Security Number 6. Sex	7. Age (In yrs. la:	st hirthday)	Hagers	If Under 24 Hi	rs. 8. Date of Birth			
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	p ,		Usual Residence of Decedent	10-0	Town or Lo						
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	death	nera		2. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rac	e - America	
9	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23a or 28a-f show the than "natural", or items 23a or 28a-f show ant, it a Madical Examiner must be notilised at	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2 No	Specify:	ono moan, etc.)	Specifi		
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B	be file la! Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Suman	ne)	
۲	ould in Men	은	Roy Edgar Harbaugh				Bertha				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examinat must be inclined at ange.		19a. Informant's Name/Relationship <i>(Typ</i> Jeanne Kane/Daughte					Rural Route Numbe Hagersto	-	State, Zip	
<u>ē</u>	Heal Heal tem 2		20a. Method of Disposition			sition (Name of natory or other place		Date	20c. Location		
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687	* × *	dlcal	d.								
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Division	f or Attend after death Director: A	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify))	reet, ractory, onice		City or Tow		or or mura	r Houle Number,
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7			30. Name and address of person who co	mpleted cause of death /!	23a) (Tun-	. /	A 0 =	1	()		
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	/Medic		DORIS ELIZABE				JULY	7 200	
	Examin	er	4a. Facility Name (If not institution, give s Caraway Manor	street and number)	E1ktor	r Location of Death		4c. County of	
	Funeral		5. Social Security Number 6. Sex			If Under 24 Hrs.	8. Date of Birth (Month, Day Dec 27		9. Birthplace (State or Foreign
	Director		222-05-6444]M 2 1 Yrs.	Months Days	Hours Will.	Dec 27	1920	Delaware
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. In side City Limits
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	s 23a	Funeral Director	4 Canal Dr.	12. Was Decedent Ever in U.S. 13.	21921			U.S.A.	- American Indian,
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93	rel', o	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🙀 No	Specify:		Specity:	White
21215-0036	illed within 72 hours after death with the Maryland Hygiene. yther then "neturel", or Items 23a or 28a-1 show yth: the Medical Exament must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade	e completed) (Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of worki	ng	16b. Kind of Busi	· ·
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ylaı	ould b Menta	To Be	Ralph Brice			Myrtle			
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty) Carolyn Little		ling Address (Street and Box 7				MD • 21915
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other then "neturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Madical Exam are must be colified at ODGs.		21. Signatur > *Fyner Service cense	M00510 1	22. Name and Addres alena Fu 18 West	ss of Facility ineral H	ome of	Stephe	en L. Schaech
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П	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown		Other (specify)			Mont	h Day Year
P.O.	that the	y Ph		ntributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to lhe cause of death?
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ion	Attending or death. ector: Atterby the fune	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		Yes 2 □ No			
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	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical C		sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	1 2 0 n -	29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)
			y und 1	112500		564	10	117/2	00)
	H			ompleted cause of death (Item 23a) (Type		omin 7	0 000	i1+~~	MD 21012
	Sta		Paul Katz 31. Date filed (Month, Day, Year)	32. Begistrar's Signature	outh Bor	remia AV	e. Cec	rrcon,	MD. 21913
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John William Mowbray, Sr. 3 -7 2003 MILIC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/10/1922 Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 220-09-7435 83 Director VA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-t show the Medical Examinar must be notified at 1X Yes 2 No MD Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1333 Marshal Street 21740 or items 23a HS Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: It Item 27 is marked other than "natural", or Iter 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Painter other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Clark Mowbray Lola (unk) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: It Item 27 is any njury or other trau once. Vivian L. Mowbray / Wife 1333 Marshal Street, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 06/23/2005 Smithsburg, MD 21. Signature of Funeral Service Licery ee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deathy Immediate Cause (Final disease or condition resulting in death) - Cardio i Pnysician /Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ticesu The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy 1 🗌 Yes 2 **5** No Hospital or Attending Phyalcian: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medicai Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 🖼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier pletely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2, To the F To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 D354 6-22-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7ANVIR A PASHA MD 1172 1122 OPAL CT. HAGERSTOWN MD LITYO 31. Date filed (Month," Day, 'Year) 32. Resistrar's Signature JUN 2 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 0 0 5 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 18, LEOLA W. MOORE JUNE 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CRESCENT CITIES NURSING CENTER PRINCE GEORGES RIVERDALE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) MAY 22, 1928 9. Birthplace (State or Foreign Funeral 6. Sex Months Days Hours Min. 1 □ M 2√2 F 77 WASHINGTON, DC 579-36-6661 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exament in the modified at DC WASHINGTON X□Yes 2□No Director the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4380 BENNING RD. 20019 USA NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after (Health and Mental Hygiene. em 27 is marked other than "naturai", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: BLACK þ 3 ☐ Widowed 4 ☆ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8TH CLERK PVT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be BERT WATKINS PEARL HANKINS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ARTHUR MEDLEY SR./ COUSIN 4380 BENNING RD. SE WASHINGTON, DC 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If ite
any injury or of 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 6-22-05 ALEXANDRIA, VA 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME
4308 SUITLAND ROAD SU 21. Signatura of Funeral Service Licensee ME OF MARYLAND, INC. SUITLAND, MD 20746 lawara 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

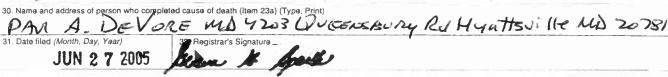
Immediate Cause (Final disease or condition On not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Liver CANCER - Arinary Immediate Cause (Final disease or condition resulting in death) Pnysician Metaltasc months /Medical **Examiner** Sequentially list conditions, Due to for as a consequence of). Examiner Lavy, Guong to find editional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Encephalopally 1 Yes 2 No 3 Probably 4 Unknown Completed Perinheral Vascular Biscate 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy try pertension XXNo 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After XXNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a

To the Within 2 State

31. Date filed (Month, Day, Year) JUN 2 7 2005

29b. Signature and title of certifier



wire a

Registrar

Medical

29a. Certifier

(Check only one)

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D01852

29d. Date signed (Month, Day, Year)

JUNE 22 2005

	1.	For State Registrar	State of Ma	ıryland		rtment of H		Mental Hygi	ene .2005	22746
Physician		Decedent's Name (First, Middle, Miriam	F. Mitch	ell				2. Date of Death Month June	25,20°0	3. Time of Death 12:10PM
/Medical Examiner		Facility Name (If not institution, 114 Burning	give street and number)				Plata		4c. County of E	Death :les
Funeral Director	2	Social Security Number 214-36-9759 Sual Residence of Decedent	6. Sex 7. Age 1	6 (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		,1937 ⁹	Birthplace (State or Foreign Country) Maryland
Maryland -f show	10	a. State 10b. County	arles		Town or Loo					10d. Inside City Limits 1
with the	10	e. Street and Number	Ruch Dlac	20		10f. Zip Code	546	10	g. Citizen of Wha	t Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28e-f show suppring or other treumatic event, the Medical Examinational Legical Approach. To Re Completed by Eurora Director	2	. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces?		ì	Vas Decedent of Hi Yes, specify Cubar		Specify Yes or No- to Rican, etc.)	14. Race - A	American Indian, Vhite, etc. White
ed within 72 hor ygiene. her than "netur. it, the Medical	omplete	15. Decedent'. (Specify only highest Elementary/Secondary (0-12) 1 2			(Give life. L	ent's Usual Occupa kind of work done d DO NOT use retired, memaker	uring most of wo	orking 1	6b. Kind of Busine	ess/Industry Home
Mental Hyg arked other atic event,	מ 17 מ	r. Father's Name (First, Middle, L Joseph Hemir		,			18. Mother's Na Albert	me (First, Middle, M ina Hem	,	
nd 2 sho nd 2 sho alth and 1 27 Is ma r treuma	1	9a. Informant's Name/Relationsh Karen Grooms/						ural Route Number, a Plata,	-	te, Zip Code) 646
Pages 1 and nent of Health of Health 27 into or other talls	20	Da. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (Sp		cerr	netery, cren	sition (Name of natory or other place Leart Ce			oc. Location - City Plata	or Town, State , Maryland
permit. Departm Importe any inju	2	1. Signature of Funeral Service L		MODA				FUNERAL LA PLATA		P.A.
Physician /Medical	l/ d	3a. Part1. Enter the disease, or of shock, or heart failure. List of mmediate Cause (Final isease or condition esulting in death)	complications that caused only one cause on each ling.	LEV	Do not ente	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
Examiner be executed sician and burial-transit Examiner	Sit d'Oth	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (1963) of the line aut initiated events soulting in death) Last	b. Due to (or as	a conseque	nce of):					
cate be	Medica	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	eath 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
quires that n signed build be deta	2 2	art II. Other significant condition	ns contributing to death b	ut not resulti	ing in the ur	ndertying cause give	n in Part I.			te to the cause of death? Probably 4 Junknown
	- Louibiete							24a. Was an autopsy perform	ed? prior	e autopsy findings available to completion of cause of h?
hysician hysician his certifical	2	5. Was case referred to medical examiner? 1 □ Yes 2 ¼ No 7. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investig		v 2	VOutpatien 8b. Time of Injury	28c. Injury Work	at Nursing	eath <i>(Check only one</i> Ho <i>me</i> 5 Xesider 28d. Describe how	nce 6 Other (Specify)
al or Attendi safter death. I Director: A d in by the fu	z eruncation:	3 Suicide 6 Could n 4 Homicide determi	ot be 200 Place of Inju	ury - At hom c. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number o State)	or Rural Route Number,
To the Hospita within 24 hours To the Funeral completely filled	legical 2	9a. Certifier 1 Certifying (Check only one) 1 Medical E	g Physician: To the best examiner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred at the time vestigation, in my op	e, date and plac sinion, death occ	e, and due to the car curred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
To the within To the comp		9b. Signature and title of pertifier	>			29c. License	2509	29	d. Date signed (M	
B15		O. Name and address of person of Meindard Smi					er, Su	ite 100	Waldor	f,MD.20602
State Registra	e 3	1. Date filed (Month, Day Year)				parte				

ADH DARREN ORRISON O5-4273

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 16b per fh 9845 7-11-05 vt.

Amend item 16b per fh 9845 7-11-05 vt.

Amend item 16b per fh 9845 7-11-05 vt.

			For State Registrar	State of Ma		ntificate of Death		Reg. 12 0 0 5	22747			
	Physici	an	1. Decedent's Name (First, Middle, La	_			2. Date of Dea Month	Day Yea				
	/Medic		Darren Fetz		4b. City, Town, or Location of	JUNE	23, 2005 2235 P M					
1	Examin	er	4a. Facility Name (If not institution, giv UNIVERSITY HOSPI			BALTIMORE CITY		40. 000, 07 20	· ·			
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Under 24		h 9. E	lirthplace (State or Foreign Country)			
	Director		224-31-460/	Ж м 2□ F	37 Yrs.	Months Days Hours	Min. 8. Date of Birt (Month, Date of Oct.19	,1967 W	V			
	land ow	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits			
	Mary P-f eh	tor	WV Hampsh	ire	Levels				1 ☐ Yes 2 🕱 No			
	or 288	Funeral Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What	Country?			
	23a c	raiD	HC-60 Box 69E			25431		USA				
	items	une	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.			
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 X If Yes, Give Year or Dates:	40	1 ☐ Yes 2 No Specify:		Specify:	hite			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel', or Items 23a or 28a-f ehow importent: If Item 27 is marked other then "naturel', or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Evarili at must be notified at ance.	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occupation kind of work done during most of DO NOT use retired)	of working	16b. Kind of Busine	ss/Industry			
12	vithin ne. hen "	mpi	Elementary/Secondary (0-12)	College (1-4or 5	i+)	ce trimming	_	Landscaping				
	ould be filed with Mental Hygiene arked other the atic event, that	o Co	11 17. Father's Name (First, Middle, Last	·)	11		s Name (First, Middle,	Maiden Sumame)				
Maryland	ld be ental ked o ic eve	To Be	Frank G. Or	rison		Jea	n E. Marcu	m				
	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship			ng Address (Street and Number			, Zip Code)			
	and 2 saith a n 27 is		Frank G. Orriso	n (father). Box 261 Slan						
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 [Removal from State	_	osition (Name of matory or other place)	6/30/05	20c. Location - City				
	rtmen rtment: rtent:		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	(h)		mation Service 2. Name and Address of Facility		Wincheste	***			
	Departiment Department		Dames K	Xle		2.0. Box 270 Au	gusta, W		IIIC•			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused one cause on each li	the death. Do not en ne.	ter the mode of dying, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death			
		Z. 3	Immediate Cause (Final disease or condition resulting in death)	a aunsh	s of Dema	nd ches	+	Onoctano Dodin				
			resulting in death)	to (or as	a consequence of):							
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68760	rtificate b ng physic as the b	ledicai		d								
	± 0 €	υ/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				23d. Date of	delivery			
. Box	death e atte	Physician/N	in the past 12 months?	1 ∐Live birth 4 ☐ Pregnant a 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year			
P.0	at the de by the a stached	Phys	9 Unknown				OZa Dida		to the cause of death?			
	The law requires that the death cer tte has been signed by the attendir page 2 should be detached for use	þ	Part II. Other significant conditions	contributing to death t	iut not resulting in the i	underlying cause given in Part I.	1 🗆 1		Probably 4 Unknown			
Ö	w require been si should I	etec						an 24h Were	autopsy findings available			
Vital Records,	he law e has	Completed					autor	rmed? prior death	o completion of cause of			
ta		0	25. Was case referred to medical			26. Place of	of Death (Check only of	2 No 1 1 Y	98 2 10			
Ž	S 0	To B	examiner? 1∑Yes 2□No	Hospital: 1 Inpati	ent 2 ER/Outpatie		sing Home 5 Resi	dence 6 Other (5	ресify)			
n of	fter the		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	ary 28b. Time Injury	of 28c. Injury at Work? ↑ M 1 □ Yes 2 📉	6.1	now injury occurred	hot			
Sio	Attending r death.	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	5000	Rural Route Number							
Division	after of Direction by	Certification:	4 Homicide determine	28e. Place of In building, e	City or To	yn, State) Cole	nerrestord					
_	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 ☐ Certifying F	hysician: To the best	of my knowledge, dea	th occurred at the time, date and nvestigation, in my opinion, death	place, and due to the	cause(s) and manner	as stated.			
	the Ho in 24 the Fu	ledical	onu)	and manner s			occurred at the time,					
	To the within 2 To the complet	Z	29h. Signature and title of certifier	ΩM		29c. License number OCME		JUNE 24.	onth, Day, Year) 2005			
		1	tatellion	-10th	at Ma		- A	JUIL 27,	200)			
	1		30. Name and address of person who	OLCA - P	AK MD	111 Penn Stre	et Baltim	ore, Maryl	and 21201			
		ate	31. Date filed (Month; Day, Year)	2005 32. Pagist	ar's Signature	bale						
	Regist	rar	JOF TI	2003	Man to 1							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 27 June 3:10 AM Margaret Elizabeth O'Brien 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hagerstown Beverly Health Care If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1□M 2X F 82 Yrs. 002-14-6539 July 31 1922 New Hampshire Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington 10e. Street end Number Hagerstown 10f Zin Code 10g. Citizen of What Country? 1908 Applewood Drive 21740 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Loan Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen O'Conner James Edwin O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. O'Brien (Brother) 1908 Applewood Drive Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t XBurial 2 □ Cremation 3 □ Removal from State July 7,2005 New London New Hampshire 4 ☐ Donation 5 ☐ Other (Specify) Elkins Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N Hagerstown, Maryland 21742 Zen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one ceuse on each line. Onset and Death Accident Immediate Ceuse (Final disease or condition resulting in death) Vascular Cerchio Due to (or as a consequence of): pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ønknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show any fujury or other treumatic event, the Madical Exertines Derivatilied at once.

Saltimore, Maryland 21215-0020

Physician/Medical Examiner þ Completed Be Medical Certification: To

Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the buriel-transit Division of Vital Records, P.O. Box 68760, use as t page 2 should death within 24 hours after death To the Funerel Director: , completely filled in by the

Sit	1-10	
	Acceptance	

State Registrar

29b. Signature and title of certifier

6 Could not be determined

29c. License number D0060396

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HED

1126

1 ☐ Yes 2 ☐ No

0

FARID 31. Date filed (Month, Day, Year) JUN 28 2005

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signature B. Specter

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

		,	1 - For State Registrar	State of M	arylan		artmen rtificate			and M	F	10g. N2 (005	2274	9		
	Physici	an	1. Decedent's Neme (First, Middle, La								2. Date of Dea	Day	Year	3. Time of D			
P.S.	/Medic		William 4a. Facility Name (If not institution, give	Oglesby)		4b City	Town or	Location o	f Death	June 19		unty of Deeth	1300	М		
	Examir		ANCHORAGE NURSING			ON	,		SBURY				VICOMIC				
Ī	Funeral Director		215-90-3017	Sex 7. Age (In yrs. last birthday)			If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 9/19/	, _{Year)}		Birthplace (State or Foreign Country) INKNOWN			
21215-0036	nyland show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											10d. Inside City				
	Ba-f	ecto	Maryland Wicomi	co	alisbu								1 XYes 2 No				
	th with the 23a or 2 list be n	To Be Completed by Funeral Director	10e. Street and Number 105 Times Square				10f. Zip 21	801			10g. Citizen of What Country? USA						
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importents: If item 27 is marked other than "netural", or Items 23e or 28e-f show any figury or other traumatic event, the Modical Execution mail be notified at ODGE.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes	ofy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: black				
	rithin 72 hou ne. hen "neture Medical E		15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	Give (Give life.			kind of woi DO NOT us	Usual Occupation of work done during most of working OT use retired)					16b. Kind of Business/Industry				
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Maryland	ind 2 shoulalth and Miss. 27 is mari	F	19a. Informant's Name/Relationship (Cheryl Senkbeil/g	**					nd Numbe	r or Rura	Alisbury			ip Code)			
nore,	Pages 1 a ant of He it: If itsm y or othe		20a. Method of Disposition 1 Burial 2X Cremation 3 4 Donation 5 Other (Specia		0	Place of Disponentery, crem	natory or o	ther place		6/21	Date 7		ion - City or T				
Baltimore,	permit. P Departme Importen any injur		Salisbury Crematory 6/21/05 Salisbury, MD 21. Signature of Funeral Service Licenses **All Community** **Community** **Salisbury Crematory 6/21/05 Salisbury, MD **Professional Association Support Suppor											sociati	on		
	Pnysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												en eath		
	/Medical Examiner		resulting in death)	a. Due to (or as a consequence of):											•		
1760,	ate be executed hysician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying traces of a part that initiated events resulting in death) Last	c. Due to (or as													
.O. Box 68	death certific e attending p id for use as 1	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	death 3	Ectopic pro					23d	. Date of deliving Month	rery Day Yea	ar		
S, D	w requires that been signed b should be deta											tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
Vital Record	Physician: The law requires that the this certificate has been signed by the rai director, page 2 should be detached.	Completed	OF Western Land to make the		24a. Was auto perfo 1Yes					psy prior to completion of cause of death? 1 Yes 2 No							
o	ding Physicia h. After this certi funeral directo	on; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manper of Death 1 ☑ Natural 5 ☐ Pending	ER/Outpatien 28b. Time of Injury	26. Place of Death (Check only one) ont 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) of 28c. Injury at Work? 28d. Describe how injury occurred												
Division	or Atten ifter deat Director; in by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospitel or within 24 hours after To the Funeral Direct completely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of examina	wiedge, death tion and/or inv	occurred avestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	ause(s) and date and pla	d manner as a	stated. to the cause(s)			
	To the within To the Comp	Me	29b. Signature and title of certifier				29c	. License	number				gned (Month,				
	3		> zale Noh				0077354					June 2019 2005					
	19		30. Name and address of person who	completed cause of	leath (Item	23a) (Type,	Print)	, 5	ALIS	Byn	27.42	MA	4				
	Sta Registr		DR. USHA NATE	2005 32. Rest	rar's Signa	ture	barle	,	-								

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)		partment of Health and ertificate of Death		2005 2275 3. Time of Dec						
Physic		Eleanor Louise P				ay Year	atn M					
/Medi Examii		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		c. County of Death						
		Holy Cross Hospi	tal	Silver Spring		Montgomery						
Funeral Director		5. Social Security Number 6. Security Number 420-12-2297 Usual Residence of Decedent	7. Age (In yrs. last birthday 84 Yrs.	/ If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Fo Country) 1921 Alabama	oreign					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23e or 28e-f ehow eny injury or other treumetic event, the Medical Examinar must be notified at once.	Funeral Director	10a. State 10b. County Maryland Montgo	nery Silver	Spring		10d. Inside City Li 1 ☐ Yes 2	_					
with the	Dire	10e. Streel and Number		10f. Zip Code 20902	10g. C	itizen of What Country? USA						
ns 23	erai	11119 Dayton Str			Specify Yes or No-	14. Race - American Indian,						
ours after o ai', or iter Exember	by Fun	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	to Rican, etc.)	Black, White, etc. Specify: White						
ithin 72 ho le. len "natur Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Giv life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	prking	Kind of Business/Industry	/Industry					
ed wi ygien ygien th	ပ္ပြ	12	Hor	nemaker		Own Home						
ould be fil Mental H Merked ott	To Be	17. Father's Name (First, Middle, Last) Lawrence B. Phe	-	18. Mother's Na Daisy 1	· · · · · · · · · · · · · · · · · · ·							
12 sh hand 7 is m treum		19a. Informant's Name/Relationship (Ty		ling Address (Street and Number or R								
1 and Health em 2	100	Frank Puliatti/ H		Dayton Street, obsition (Name of ematory or other place) Ju	Date 20c I	ocation - City or Town, State						
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permit. Pages Department of Importent: If It ony injury or one		21. Signature of Funeral Service Licens		Prancis Address of Facility Francis J. Collins 500 University El	Funeral Ho	ome Inc ver Spring, MD 20	90					
Physician /Medical		23a. Part1. Enter the disease, or sample shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	tations that caused the death. Do not enter cause on each line. Critical Aortic S Due to (or as a consequence of):		c or respiratory arrest,	Approximate Interval Between Onset and Deat 6 Years						
Examiner	miner											
ate be executed hysician and the burial-transit	ical											
To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year						
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sician: The law require certilicate has been si lirector, page 2 should b	ompleted	Disease, Chronic	Renal Failure		24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death?	autopsy findings available completion of cause of					
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tending Physician: The leath. Jeath. tor: After this certificate ht the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	scribe how injury occurred						
To the Hospitel or Attendi within 24 hours atter death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)						
To the Hospitel or At within 24 hours after of To the Funerel Direc completely filled in by	edicai	29a. Certifier 1 S Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)						
To the comp	Σ	29b. Signature and title of certifier	2	29c. License number	29d. Da	ate signed (Month, Day, Year)						
4		30. Name and address of each who co	empleted cause of death (Item 23a) (Type			ine 21, 2005						
		Julie Krivy, M.D		venue, #306, Silve	er Spring, Mo	20902						
્ર Sta Regist		31. Date filed (Month, Day, Year)	Registrar's Signature	ules								

			1 - For State Registrar		Marylar	_	artment <i>rtificate</i>				ental H	ygien Reg. N		5	227	51			
	Physici /Medio		Decedent's Name (First, Middle Jean Fr	a, Last) anklin							2. Date of D Month June		2005	Year	3. Time 4:00	of Death			
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	Funeral		5. Social Security Number	6. Sex 12X M 2 ☐ F	7. Age (In yrs.	.,	If Under 1 Months	Year Days	If Under:	Min.	8. Date of B (Month, D	irth ay, Yea <i>r,</i>)	9. Birth Cou	place (State untry)	or Foreign			
١.	Director		Usual Residence of Decedent		77	Yrs.				1	April	21,	1928	Ca	lifor	nia			
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							T	10d. Inside	City Limits			
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	72 hours after death with the Maryland natural', or items 23a or 28e-f show dical Examinar must be notified at	Funeral Director	11. Marital Status Unknow	n 12. Was Dece	dent Ever in U	l.S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Spec	cify Yes or N	lo-							
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an	ld be ental ked c	To B	Frank Jack Pi	chler							hristi			,	Rockville, M ity or Town, State oring, Mary land include interval Between Onset and Death of delivery Day Year				
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street a	nd Numbe	r or Rural	Route Numl	ber, City	er, City or Town, State, Zip Code) 20850						
Ž	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show then then than "natural" or items 23a or 28e-f show then treament event, It a Madical Examinar must be notified at		Bernadette Swe	eney/ Pers	onal R														
ore	Tan to		20a. Method of Disposition	0	1 ,	Place of Dispo	sition /Name	of		Da	ate								
Baltimore,	Pages nent of a		1 Burial 2 Cremation 1 Other (S _i			te of He				20	e 22, 05	Silv	or S	mrin	Mo.	www.land			
	permit. Pages Department of Important: If is any injury or	21. Signatur of uneral Service Licensee								Funera	uneral Home Inc								
<u> </u>	89 = 9		wolch tole 500 University Blv									d, W, Silver Spring, MD 20901							
	Pnysician /Medical										kuo	wh	Interval Be	etween					
В	Examiner	er		Due to (or as a conseq	uence of):					J								
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (:	y as a sonseq	uanca or).								-					
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Ó,	exerian ar	EX	resulting in death) Last	or as a conseq	r as a consequence of):														
8760,	cate be executed physician and the burial-transit	Ical																	
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Вох	that the death certific ed by the attending p detached for use as	Physiclan/Medical	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	Ideath 3[Ectopic pre						23d. Date Moni			Year		
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σ.	The law requires that the tee has been signed by the bage 2 should be detache		Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	nderlying cau	ise dive	n in Part I.		23e. Did	tobacco i	use contril	bute to t	he cause of	death?			
ds,	uires tha signed Id be dei	d by		, , , , , , , , , , , , , , , , , , , ,							_	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unit							
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ta		e Cc	25. Was case referred to medical						OC Disease		1 Yes	2 No	1 (Yes	2010				
>	Physician: The this certificate har director, page	0 0	examiner? 1 ☐ Yes 2 🔀 o	Hospital:	patient 2 🗆	ER/Outpatier	nt 3[] DOA	Other			th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)								
1 of	문 # F	T:u	27. Manner of Death	28a. Date o	f Injury	28b. Time of					d. Describe				<i>y)</i>				
Ö	2. 本道	atlo	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Year 2 No 28d. Describe how injury occurr																
Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural City or Town, State)					al Route Nur.	nber,			
٥	tel or A rs after el Dire	Cer		W	g, (- <i>p</i>					1	ony or 10	www, clare	"						
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) Certifyin 2 Medical I	g Physician: To the Examiner: On the ba and mann	sis of examina	wledge, death tion and/or in-	n occurred at vestigation, in	the time	e, date and inion, deat	d place, ar h occurred	nd due to the d at the time,	cause(s) date and	and man place, ar	ner as s nd due t	tated. the cause(s)			
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	00	0.00			_	number						Day, Year)				
)	10		men	Alle	ella	MAD	1)3	382	62	_	Ju	ne 22	2, 2	005				
			30. Name and address of person and Anurita Mendi	who completed cause niratta, M		01 Res		Blv	đ, #3	30, I	Rockvi	lle,	MD 2	2085	0				
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7	2005	gistrar's Signa	ture for	while												

State of Maryland / Department of Health and Mental Hygiene Rag. NZ U () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JOSEPH USKARICH 28 12-40AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Nursing Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 6. Sex **Funeral** 8. Date of Birth (Month, Day, 1 2M 2□ F Months Days Hours Min 7370 212-70-Director 46 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Harford Aberdeen MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 642 Andrews Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Menial Hygiene. Important: if item 27 is marked other than "na any injury or other freumatic event, the Made once. (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Disabled 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph M. Puskarich, Sr. Asta Ritson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2557 Topaz Drive, Novado, CA 94945 T. Pete Oiderma (Half-brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/08/2005 ⁴ ☐ Donation 5 ☐ Other (Specify) Harford Memorial Cardens Aberdeen, Maryland Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 333 S. Parke St., Aberdeen, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last to (or as a consider ence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 2 □ No 1 Yes fo the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of after death. 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Baltimore Eutow 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

			1 - For State Registrar		epartment of Health and N		iene 2005	22753
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
ı	/Medic	al	4a. Facility Name (If not institution, give a	M. PATSONS	4b. Ciby Town, or Location of Death	6	15 05 4c. County of De	1/ AM M
	Examin	er	12138 Callege 1	PZ	PR ANNE		Jomes	
	Funeral Director		5. Social Security Number 6. Sex	M 2XF 7. Age (In yrs. last birthe	Months Days Hours Min	8. Date of Birth (Month, Day,		ountry) (State or Foreign
	D D		Usual Residence of Decedent 10a. State 10b. County	100 City Town		127	1948	
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	or 28a)irec	106. Street and Number) Into a	10f. Zip Code	10	og. Citizen of What C	Country?
	s 23a	erai	5114 TRINIDAD	Street 12. Was Decedent Ever in U.S.	20737		USA	
9	after do	by Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - An Black, Wh	
21215-0036	72 hours after death with the Maryland Insture!; or Itams 23a or 28a-f show disal Examiner must be multiled at	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu	Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	ACK
215	within 72 ene. than "na	Completed	(Specify only highest grade	completed) (6	lecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) , , ,	king	16b. Kind of Busines	s/Industry
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land	2 should be filed withir and Mental Hygiene. Is merked other than aumatic event, Ire M	To Be	-7	LORE WILL	18. Mother's Nam	ne (First, Middle, N	AAAA	Brank S
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Madical Examiner man be notified at		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or Ru	ral Route Number,	or Town, State,	Zip Code)
-	1 and Health tem 27 other tr	(have the Arsun 20a. Method of Disposition	15, Utughter 12	Disposition (Name of	Rinks 1	20c. Location - City of	2/853
Baltimore	Pages nent of I int: If it		Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	GATORIS 6	0/05 /	Lehan	MO
Balt	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service License		22. Name and indress of Facility	chn-c 5mi	the French	al Hone
	-		23a. Part1. Enter the disease, or compli	cations that caused the death. Do no	t enter the mode of dying, such as cardiac	Alis buy		Approximate
ı	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	Bornt Com	ren		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)		7.00		o con est
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8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	dicai E		Date to (or as a consequence or)	,			
9	artificate ing phys e as the	0	IF FEMALE:					
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P.O.	that the ded by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				
	signed I	by	Part II. Other significant conditions con	tributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did toba		robably 4 Dunknown
Records,	s been si	Completed				24a, Was an	24b. Were a	utopsy findings available
II Re		Comp				autopsy perform 1 Tes 2	prior to death?	completion of cause of s 2 No
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Division	Attending r death.	icatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No	006 1		
Di∨	al or A s after il Direct	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office	City or Town,	eet and Number or F State)	fural Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Phys	ier: On the basis of examination and/	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Mon	
•	3		Valort 2. L	linton, 10	0005677	6	6/20/0	5
	Z		30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty	rpe, Print) 15 E. CARROLL S	T (A)	1 < RUPW	M 21661
	Sta	4 (31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	1 757	12 341-19	10812 (180)
	Registr	ar	JUN 2 3 20	US Blown St.	Goode			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 8,20b per ft 2845 7-12-05 Wental Hygiene State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 15 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yee **Physician** 30, 2005 2:35 A Quandt Charles June Russe11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner 19800 Tranquility Circle Suite 228 Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Enth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral Months 1**X** M 2□ F April 19,1919 Maryland Director 218-10-2250 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23s or 28s-4 show ary or other traumatic event. It is McClost Examinating to nothing the notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 19800 Tranquillity Ci Suite 228 21740 Completed by Funeral .A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) News Organization 8 Mailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles P. Quandt Jesse May Lentz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EStelle V. Quandt / Wife 19800 Tranquillity Ci. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Smithsburg Crematory +6/2/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Lice 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 years Examiner Ca of Prostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Type 2 Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 2 his funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death. To the Funarel Director: After 1X Natural 5 Pending investigation 1 TYes 2 □ No 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier an D0017027 07/01/2005 cause of death (flem 23a) (Type, Print) 30. Name and addr s of person who cor

DHMH 17 Rev 1/2001

State

Registrar

17516 Virginia A

JUL 1 2 2005

31. Date filed (Month, Day, Year,

ORIGINAL

Md 21740

Wun B. Kang, M.D.

Hagerstown,

			For	State of Maryla		artment of H		_	_	000	00755
			Registrar 1. Decedent's Name (First, Middle, Last)	061	lilicate of L	Jeani	2. Date of De	Reg. No.	002	3. Time of Death
3	Physicia		Charles Addison					June 2	Day	Year	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	June 2		County of De	
	LXamii		Collingswood Nur	sing Center		Rockvil	1e		Mon	t gome:	rv
	Funeral		5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th		rthplace (State or Foreign Country)
	Director		048-10-8672	84	Yrs.			Jan. 1			nnecticut
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	Maryland Montgome	ry	ermanto	นทา					1 ☐ Yes 2 🖾 No
	r 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What C	Country?
	73a o	ai D	13663 Spinning W	heel Drive		20874			Unit	ed St	ates
	ams arms	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No Rican, etc.))- 1·	4. Race - Am Black, Wh	erican Indian, ite. etc.
36	or It	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give 194 Year or Dates:	446	1 ☐ Yes 2 ☑ No	Specity:		5	Specify:	
5-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itams 23a or 28a-f show afte avant, it a Medical Eranical must be notified at		3 Widowed 4 Divorced 15. Decedent's Edi			dent's Usual Occupa	tion		16h Kin	d of Busines	White
5	in 72 n "na	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired,	uring most of work	king	100.11	G OF DUSTITOS	amadaty
212	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Ch	emist			Te1	ephone	e Company
pu	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden S	Sumame)	
<u>yla</u>	should b	T _O	Sabin Sayles Rus				Alice	Paulin	e Fis	h	
Maryland 2121	2 short and is m		19a. Informant's Name/Relationship (T			ng Address (Street a					
	1 and dealth		Elizabeth R. Cli 20a. Method of Disposition		ter) I			el Driv Date			r Town, State
Ö	Pages nent of I unt: If its		1 ☐ Burial 2 🖾 Cremation 3 🗆	Removal from State	cemetery, crer	natory or other place Ltan Crema		1/./05			, Virginia
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-1 show amy injury or pupar traumatic avant, the Medical Examinet must be notified at once.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	M. M.	22	2. Name and Addres	s of Facility $\mathbb{D}\epsilon$	Vol Fur	eral	Home	, virginia
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	/Medical		resulting in death)	Due to (or as a cons	sequence of):	100					Jears
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9	tificat ig phy as th	0.0									
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О.	e dea the at ned fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify)				MOHUI	Day Year
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Record	he lav e has age 2	Completed		-				auto perfe	psy	prior to death?	completion of cause of
Vital	sician: Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes	2 No	1 L 1 E	s 2 No
	Physician: r this certifica ral director, i	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA Cthe	97: 4 Nursing He	ome 5 🗆 Resi	dence 6	□Other (Sp	ecify)
0	ding Ph h. After thi funeral		27. May er of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Work		28d. Describe	how injury	occurred	
sio	Attanding in death. actor: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Dian of lains. A	Abono form all		/es 2 □ No	20f Location /	Ctroot and	Mumbasasi	Rural Route Number,
Division of	l or Attand after death Diractor:	Certification:	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	eet, ractory, office		City or To		TABILIDES OF S	rurar noute Number,
	Hospital 24 hours a Funaral i		29a. Certifier 1 Certifying Ph	/sician: To the best of my	knowledge, deat	h occurred at the tim	e, date and place,	and due to the	cause(s) a	and manner	as stated.
	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my or	pinion, death occur	red at the time,	date and p	place, and di	ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title o certifier	\bigcap		29c. License	number		29d. Date	signed (Mo	nth, Day, Year)
7	D		1/2/2/	John	ــــــــــــــــــــــــــــــــــــــ	0.7	20178		740	2 2	9 2005
•			30. Name and address of person who co		tem 23a) (Txpe,	issell A	re. Ga	ithers &)()rc	\wedge	74
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	_		1 - For State Registrar	State of Maryla		artment of tificate o			Reg. No. U	05	22756
	Physic		1. Decedent's Name (First, Middle, Last DOROTHY LOUISE	•				2. Date of De Month June	Day 20,	2005	3. Time of Death 9:45 A M
	/Medi Examir		4a. Facility Name (If not institution, give Casey House	street and number)		Rock	n, or Location of I		4c. Coun	ty of Death	
	Funeral Director		432-01-3049	x 7. Age (In yrs	5. last birthday) 5. Yrs.	If Under 1 Ye Months Day		Min. 8. Date of Bir (Month, Da Mar • 2	, Year) 1920	9. Birthp Coun LA	lace (State or Foreign try)
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	or 28s	Direc	10e. Street and Number			10f. Zip Cod			10g. Citizen o		
	s 23a	eral	20119 Waringwood	Way 12. Was Decedent Ever in	118 121		20886	n? (Specify Ves or No	United	State	
036	72 hours after death with the Maryland Instural, or itams 23a or 28s-f show dical Examinat must be redified at	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)		ack, White,	etc.
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Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Thomas Reid		Todane	II OI L	18. Mother's	s Name (First, Middle,		ame)	
ary	2 should be and Mental is marked eumatic ev	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stre	eet and Number	or Rural Route Numb	er, City or Tow	n, State, Zip	Code)
ore, M	parmit. Pages 1 and 2 should Department of Heelth and Mer Important: If Item 27 is marke any injury of other treumatic once.		Earnestine Reid (20a. Method of Disposition 1 Burial 2 Cremation 3	20b.	Place of Dispo cemetery, crer		n/ana)	Montgome Date une 24,	20c. Location	- City or To	own, State
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<u> </u>	\$0 E E 9		Muchel	Min		·		ck Dr. Gai	thersbu	rg, Mo	
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Due to (or as a conse	Lung C		cying, such as ca	ardiae or respiratory a	rrest,	1	Approximate Interval Between Onset and Death Months
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of	ding Phys h. After this funeral di	tion; To	1 ☐ Yes 2 [XNo 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. I	Other: 4 Nurs njury at Work? 1 Yes 2 No	28d. Describe			Hospice
Division	5 g to 0	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of the C		reet, factory, offi	ice	28f. Location (City or To		nber or Rura	l Route Number,
	To the Hospital within 24 hours and the Funeral I completely filled	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at th vestigation, in n	e time, date and ny opinion, death	place, and due to the occurred at the time,	cause(s) and r date and place	nanner as st e, and due to	tated. the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier				ense number		29d. Date sign		**
•	1		Children	ر ا			4216114		June 2	υ , 200	J5
	10	111	Dr. Chitra kajago		715 Med	ical Ce	nter Dr.	#221 Rocl	kville,	Md. 2	20850
	Sta Regist	ate rar	JUN 27 20	32/Registrar's Sig	A A	sale?					

Secretary.

Please Type or Brint in Black Indelibie Info State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 23 2005 arbavo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, To **Examiner** 9. Birthplace (State or Foreign Country) Maryland If Unde 6 Sex Social Security Number Age (In yrs. I **Funeral** Months 1 □ M 2 🗗 F 213-42-7984 61 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant, the Modical Experiment near the notified at 1 Yes 2 No Walkersville Md. Frederick Director the 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21793 13 Liberty Street United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Finance Company 0 Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental H Be Gladys Norton Arthur Sanford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 Liberty Street, Walkersville, Md. 21793 B. Eugene Rau / Husband itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 6/24/05 Alexandria, Va. * 4 ☐ Donation 5 ☐ Other (Specify) Importa 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee, Murie Box 5038, Laytonsville, Md. 20882 P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Pneumonia** 3 Approximate Onset and Death Immediate Cause (Final Priysician Kespirato disease or condition resulting in death) /Medical ue to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 2 No 1 Tes 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 ♥ No this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 1/ Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier cal 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier June 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maniland Street 600 North Welfe 10/10 31. Date filed (Month, Day, Year) State 27

Registrar

2005

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	ÿ.		Registrar Amend #1.Per	Phys.PGC 6-28		rtificate of l				15 2	22/58
7	Physicia	an	1. Decedent's Name (First, Middle, La	st) Paul I	Brooke Re	ارمان علی التاط		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio Examin		4a. Facility Name Af not institution, give	e street and number)	7,0,1	4b. City, Town, or	r Location of Death	UNC_	4c. County		06:25A M
	LAGITIII	CI	The Johns How	olicines Hos	stich	Baltin	none Ci	tes			
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	land	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits
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	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Coun	try?
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2	e filed within al Hygiene. I other then '		12		Self	employed	18. Mother's Name ((FT) A	Enter		ent
Maryland	ntal H ed oti	Be	17. Father's Name (First, Middle, Last Paul Brooke Ro				Dorothy			10)	
Ž	2 should be and Mental Is marked reumatic ev	ပ္	19a. Informant's Name/Relationship	<u> </u>	19b. Maili	ng Address (Street	and Number or Rural I			State, Zip	Code)
	nd 2 salth ar 27 ls r treu		Joan Rothgeb -			•	y Street,				•
altimore,	is 1 and 2 of Health a item 27 ls other trei		20a. Method of Disposition		20b. Place of Dispo		Da		20c. Location -		
Ш	Pages nent of h ant: If its ary or o		1 ☐ Burial 2 【XCremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci				tory 06-25	-05	Alexand:	ria,	VA.
Balt	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral error	Bea	0)	2. Name and Address 5512 N.W.	ss of Facility Bea Crain Hwy		eral Ho wie, Ma		d 20715
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	ter the mode of dyin	ng, such as cardiac or	respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a cardi	onyonath	У					Onset and Death 1 year
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	la la					•
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):						
	uted d ansit	m	cause. Enter Underlying Cause Cincese or injury that initiated events								
oʻ	be executed sician and burial-transit	Examin	resulting in death) Last	Due to (or as a	a consequence of):						
8760,	ate be hysicia the bu	dicai		_ d							
O. Box 68	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the first time birth a light pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/			te of delive onth	ny Day Year
٣.	that the by detail		Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	ınderlying cause giv	ren in Part I.	23e. Did to	obacco use cont	nbute to th	e cause of death?
rds	quires in sign uld be	ed by						101	Yes 2 No	3 🗌 Proba	ably 4 \(\sum Unknown
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Ä	The fav	mo.							med?	death?	npletion of cause of 2□ No
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of \	Physicien: this certific al director,	ို	1 ☐ Yes 2 XNo		nt 2 ER/Outpatie		4 Nursing Home				/)
on (ion	27. Manner of Death 1. Natural 5 Pending investigation	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Wor	yat k? Yes 2 □ No	a. Describe r	now injury occur	rea	
Division	deat deat stor:	Certification:	3 Suicide 6 Could not l	De Diago of Inju	ury - At home, farm, st				Street and Numb	per or Rura	I Route Number,
Div		erti	4 Homicide	building, etc	c. (Specify)			City or Tov	νπ, State)		
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical C		hysicien: To the best of miner: On the basis of and manner sta	examination and/or in						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signe		
			· Om -	2 MD		RES	-000		June 3	24	2005
C	12 (3)		30. Name and address of person who			0 (1	imore Ma		1 1.4	- 87	
			31. Date liled (Month, Day, Year)	600 Vo			THONE MI	47 12 4	<i>L</i> 4	- 8/	
	Sta Regist		JUN 2 8 200	5 Seine	ar's Signature	de					

Amended Item 20c per F.D. 06/28/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 6:10 A M Ruth Alice Reaver 2005 /Medical June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Country Companions Taneytown Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours Min Yrs. Director 81 218-76-7327 June 24, 1924 | Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other then "neturel", or Items 23a or 28e-f show ury or other treumatic event, The Medical Experiment must be notified at ury or other treumatic event, The Medical Experiment must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits I Director 1 ☐ Yes 2 ☑ No Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3415 Bert Koontz Rd. Completed by Funeral 21787 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret ဥ E. Rigler Harry E. Reaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 is any injury or other trea Pat Hood (niece) 8920 Orndorff Rd. Emmitsburg, ND 21727-8028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Unionville, MD 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Linganore Cem. 6/29/2005 Unionville ... No 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory. P.A.
1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events Physiclan/Medical Examiner rsician and s burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760 use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 2□ No 1 🗌 Yes 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 her (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sign were and title of certifier 29c. License number WIL d address of person who completed cause of beath (Item 23a) (Type Print) Road, Westminster MD 2157 S bon ن 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JET unpend Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. 1ten#23a.27, 28a-1, perMF. (845, 7/13/05 TT State of Maryland / Department of Health and Mental Hygiene 05-04137 05-04137 Mark Stephen Ryan For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1^{Day} Month **Physician** STEPHEN June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ciuista Medical Center Charles Waldorf If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1)X M 2□ F Director 230-29-5523 Yrs. AUG.21 ,1967 GERMANY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other traumatic event, the Micrical Examiner rust be notified at 1 Tyes 2X No Director MARYLAND CHARLES WALDORF 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 1000 VICTORIA PLACE 20602 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1 \(\text{TYes} \) 2 \(\text{D}\) No If Yes, Give Year or Dates: 1985 − 1 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE natural 988 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 EASTERN ROOFING ROOFER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mehtal H Be JAMES ELIZABETH ROSE GRECH THOMAS RYAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health tem 27 i 7309 CARROLL DRIVE, BRYANS ROAD, MD 20616 ELIZABETH RYAN-MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H important: if ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 6-24-05 CHELTENHAM, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, PA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do netenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Methadone Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. detached the 9 Unknown 9 Unknown é Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death 2 No performed' certificate Yes 2 No Hospital or Attending Physician: ral director, 25. Was case referred to medical 26. Place of Death Check on one examiner? Hospital: 1 ☐ Inpatient 2 【★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 ☐ No this 27. Manner of Death 28c. Injury at Work? Fnd Month, Day Year) Find ury 28d. Describe how injury occurred After 1 Natural 5 Pending 6/17/2005 6:43 AM investigation 1 ☐ Yes 2 No death. 2 Accident unk after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found at home 28f. Location (Street and Number of Rural Route Number City or Town, State) 1000 Victoria filled in by 4 | Homicide Place Waldorf, MD 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 18 2005 June Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street MRYBRY Baltimore, Maryland 21201 DRE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 1 2005 Registrar

ORIGINAL

Charles Raines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
1- State Of Maryland / Department of Health and Mental Hygiene
Red. No.

Red. No. 05-04129 NJM Reg. No. 1 1 5 2. Date of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** Charles J. Raines 2005 0030 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

DC 8. Date of Birth (Month, Day, Year) 06-16-1963 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 212-82-4211 42 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director D.C. N/AWashington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1253 Wylie St, 20002 N.E. U.S.A. Items 23e Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. snt: If item 27 Ia marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Miorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th 4th Instructor Children Musume other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Wilson Jr. Pearl Penamon Wilson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Penamon Wilson / Mother 1253 Wylie St NE, Washington DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition jo <u>=</u> 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-24-2005 Department of Importent: If any injury or once. George Wash Cem. Adelphia, ` 4 ☐ Donation 5 ☐ Other (Specify) MD 21. Signature of Funeral Service Li 22. Name and Address of Facility D. L. McLaughlin's Funeral SVC, Inc. 1425 MD Ave, NE, Washington DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician Narcotic Intoxication complicating Hypertensive disease or condition resulting in death) /Medical Cardiovascular, Visease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by signe 1 be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? 1X Yes 2 No tha Hospital or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐ER/Outpatient 3☐ DOA Certification: To 1X Yes 2 □ No ŧ 28a. Date of Injury Found h, Day Year) 6-16-05 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Found, 1 Natural 5 Pending 11:15 P M 1 Tes investigation death. 2 Accident hours after deat 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, StateMontgomery County Detention Ctr., Rockville, MD þ 4 Homicide Detention Center 24 hours a 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 0 6 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201 Registrar's Signature

lan ma

29c. License number

OCME

29d. Date signed (Month, Day, Year)

June, 17, 2005

		-	For State Registrar	State of Maryl	•	artment of H		-	giene Reg. N2 () (15	22762
	Physici	an	Decedent's Name (First, Middle, Las WILLIAM PAUL	SNYDER				2. Date of Dea Month JUNE		Year 05	3. Time of Death 3:10 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	ΔL	4b. City, Town, or OLNEY	Location of Deat		4c. County MONT	of Death	
	Funeral Director		5//-26-410/	x 7. Age (In 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year) 6 1924	Cour	olace (State or Foreign ntry) nsylvania
	Maryland -f ehow fied at	tor	Usual Residence of Decedent 10a. State 10b. County Md. Montg		City, Town or Lo	ocation nsville				1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the	Director	10e. Street and Number	_		10f. Zip Code	22		10g. Citizen of V		•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23e or 28a-f ehow minipury or other treumetic event, its Medical Evair, act must be notified at ance.	by Funeral	20532 Farcroft 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 27 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 ▼No	ispanic Origin? (S	Specify Yes or No to Rican, etc.)		e - Americ ck, White,	can Indian,
21215-0036	d within 72 hou jiene. r then "nature the Medicul E	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12		16a. Dece (Give life.	dent's Usual Occup o kind of work done o DO NOT use retired rtographe	during most of wo	rking	16b. Kind of Bu		
Maryland 2	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) William I. S	nyder			18. Mother's Na Mary	me (First, Middle, Combs	Maiden Sumam	10)	
Mary	nd 2 shoualth and M 27 is mai		19a. Informant's Name/Relationship (7 Margaret H. Sn			ng Address (Street 32 Farcro					Code) 20882
nore,	ages 1 and of Hez		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other plac	1	Date	20c. Location -	1	
Baltimore,	permit. P Departme Importen any injury once.		4 □ Docation 5 ⊠Other (Specify 21. Senature of Furieral Service Icen		2	2. Name and Addre	ss of Facility H. Barbe	24/05 r Funera , Layton	l Home		ing, Md. 20882
	Physician /Medical		23a. Part1. Enter the disease, or companion, or heart failure. List only disease or condition resulting in death)		A ABNO	ter the mode of dyin			rrest,		Approximate Interval Between Onset and Death 2 4 0 3 15
8760,	Example of cate be executed physician and the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to inch. solicition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Use to (or as a co	resquence off:				- 0.4		
O. Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Dat Mo	te of delive	ery Day Year
Δ.	luires that n signed b ild be deta	by	Part II. Other significant conditions of Responsitions of		_						he cause of death?
Vital Records,	The faw require ate has been sig page 2 should b	Completed	LOROLARY ART	ERY DITER	DIE, D	TABETE	- 3	24a. Was autor perfo	psy prmed?		opsy findings available impletion of cause of
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o	one)		
Division of	yd Sic	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time (Injury	of 28c. Injur Wor	y at	Home 5 Resi	dence 6 Oth		(5)
Divis	el or Attending P. s after death. al Director: After tl	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, si pecify)	treet, factory, office		28f. Location (: City or Tot	Street and Numb wn, State)	er or Rura	al Route Number,
	Hospit 4 hours Funers ely fille	Medical C		ysician: To the best of miner: On the basis of exa and manner stated.							
	To the within 2. To the complet	M	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
)	511		my fre				3630	4	June 2	1	2005
-			30. Name and address of person who FRNUTE J. MAYO,	70 16220	FREDER	ZCK RUA.	0 #213,	GAITH	ERIBUR	6. 1	10 20877
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 7 200	5 Registrar's	Signature (pa	de					

State of Maryland / Department of Health and Mental Hygiene State State Registre AMEND ITEM #5 PER FH C846 8/03976 Grappe of Death Reg. 2. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Harriet В. Snyder 11:10 P^M June 22 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 14,1909 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2X F 95 July Illinois Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show any hipty, go ther treumatic event. If a Modified Examiner must be notified at once. 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 1 X Yes 2 ☐ No Director Montgomery Gaithersburg Md. 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 333 Russell Ave. #507 20877 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Internal Revenue Editorial Work Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Rankin George Orton Bickley ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Schindel (Niece) P.O. Box 27 Orrtanna, PA 17353 20b. Place of Disposition (Name of cemetery, crematory or other place) June 27, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Brentwood, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 IRKUAS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Sepsis disease or condition resulting in death) Days /Medical Due to (or as a consequence of): **Examiner** Peritonitis Sequentially list conditions. Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit Bowel Perforation that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the as IF FEMALE nse s 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No jō Month Day Year 4 Pregnant at time of death 5 Other (specify) 0.0 the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ pe 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has b autopsy rmed? 2 No certificate 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) D20148 June 23, 2005 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven H. Dolinsky, M.D. 911 Russell Avenue Gaithersburg, MD 20879 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 10 ever Registrar

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State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2005

. Registrar's Signature

			1 - For Stete Registrar	State of Ma	aryland	-	artment of I				ene 2005	22765
	a		Decedent's Name (First, Middle, Las	t)			outo or	200111		2. Date of Death		3. Time of Death
	Physici /Medic		Frances D.							June 27		0526 M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town,				4c. County of Oe	
			Carroll Hospital 5. Social Security Number 6. Se		o (la ura la	st birthday)	If Under 1 Year	ninste		Dotte of Birth	Cari	
	Funeral Director			M 2/⊡ F /Ag	81	Yrs.	Months Days		Min.	8. Date of Birth (Month, Day, Mair 5	Year) 1924 Pe	lirthplace (State or Foreign Country) Ennsyivania
	p .		Usual Residence of Decedent 10a. State 10b. County		10= Cit.	Town and a						
	aryla ehov	'n		1	TOC. City,	, Town or Lo		estmir	ster			10d. Inside City Limits 1 ☐ Yes 2√ No
	the M	Director	Maryland Carrol 10e. Street and Number						10001	140	- 000	
	with Sa or		2223 Coon Club	Road			10f. Zip Code	2	1157	10	g. Citizen of What USA	,
	death	Funerai	11. Marital Status	12. Was Decedent			Vas Decedent of I	Hispanic Ori	igin? (Spec	city Yes or No-		nerican Indian,
36	permit. Pages 1 and 2 should be tilled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Modical Examinar must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			fYes, specify Cub I□Yes 2⊠ No			Rican, etc.)	Black, Wi	nite, etc. White
ğ	2 hou	ted	15. Decedent's Ed			16a. Deced	lent's Usual Occu	pation		10	6b. Kind of Busines	ss/Industry
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	ed wi	Con	11				Homemake	-				Alle
Maryland	uld be fil fental H rked otl	To Be	17. Father's Name (First, Middle, Last) George Gudac						er's Name ROSE	(First, Middle, Ma "Unknow		
ary	and Non		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street	and Number	er or Rural	Route Number,	City or Town, State	, Zip Code)
	and 2 saith n 27 i		Kathleen Nowicki,	daughter				erry I	Lane,	Westmin	ster, MD	21157
altimore,	jes 1 of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other pla	ісв)	Da	ate 20	Oc. Location - City	or Town, State
Ē	Pag tment tent:		*4 □Donation 5 □ Other (Specify)		-	Memoria				Finksbur	
Ba	permit Depar impor any in		21. Signature of Figneral Service Licent	MOO	723 M		Name and Address 934 Sout		· 15.		eral Home	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death.	Do not ente	er the mode of dyi	ng, such as				Approximate
	Physician		Immediate Cause (Final disease or condition		J47	MI	w	M				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						0
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90,	ficate be executed physician and s the burial-transit	E	resulting in death) Last	Due to (or as	a consequ	ence of):						
8760,	physis the t	dical		d								
×	death certifi e attending id for use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of d	elivery
. Box	0 0	by Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnanc Other (specify) _	У			Month	Day Year
о. О	at the de by the a tached	hys	9 🗆 Unknown	9□ Unknown								
Records, I	The law requires that the te has been signed by th bage 2 should be detache		Part II. Other significant conditions co	intributing to death b	ut not resul	ting in the ur	nderlying cause gr	ven in Part I.		23e. Did toba	/	to the cause of death? Probably 4 □Unknown
S	aw require s been sig 2 should b	olete								24a. Was an	24b. Were	autopsy findings available
		Completed								autopsy performe	prior to	completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						of Death	(Check only one)		
<u></u>	Physi this c	မ	1 105 2 100	Hospital: 1 Inpatie		R/Outpatien	3 DOX				ce 6 □Other (Sp	ecify)
uc	Jing After fune	ion	27. Mann of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 []∣		3d. Describe how	injury occurred)
Division of	deat deat ctor: y the	ficat	3 Suicide 6 Could not be		ury - At hor	ne, farm, stre	eet, factory, office	,103 2		Bf. Location (Stre	et and Number or I	Rural Route Number,
	- 8 - 6	Certification:	4 Homicide	building, etc	c. (Specify)					City or Town,	State)	
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in	edical C	29a. Certifier 1 Certifying Phy	/sicien: To the best of iner: On the basis of	of my know	rledge, death	occurred at the ti	me, date an	d place, an	nd due to the cau	se(s) and manner	as stated.
	To the H within 24 To the F complete	Medi	one)	and manner sta	ated.							
		~	29b. Signature and title of certifier	Ma :to	1	M	29c. Licens		8	290	d. Date signed (Mor	ntn, Day, Year)
	NST		Tour	pull		.)		539		8	101/2	-03
	4.4		30. Nante and address of purson who g	FLAV		23a) (Type, I	3555	CENT	ER	T, WE	STHINST	ER HD 21157
**	Sta Registr		31. Pate filed (Month, Day, Year) JUN 2.8	32. Registra 2005			berle					
		0				7						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NG U 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ື2005 **Physician** JUNE 26, DONALD ELWOOD STAUFFER, SR. 3:43 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WESTMINSTER NRSG & REHAB CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 12,1935 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. XXM 2□F 213-32-5461 69 Director MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at MARYLAND CARROLL HAMPSTEAD 1 ☐ Yes 2 XX Yo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4418 BLACK ROCK ROAD UNIT 10 21074 UNITED STATES Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" ~ " any injury or other traumatic success." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELWOOD WESLEY STAUFFER JOAN E. WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMA E. STAUFFER/WIFE 4418 BLACK ROCK RD, UNIT 10, HAMPSTEAD, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State CARROLL CREMATION 6/28/2005 HAMPSTEAD, MARYLAND ^¹ 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MYFRS-DURBORAW FUNERAL HOME, P.A. WESTMINSTER, MD 91 WILLIS STREET 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOENO CAZOW ONA Priysician OF 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 ANo Year Month Dav 4☐Pregnant at time of death 5 🗌 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? Yes 2 No 2 🗆 No 1 Tyes 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Voursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 EP/Outpatient 3 DOA this unerai 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending To the Hospitel or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31660 27 2005 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS K. GALVIN III, 291 STONER AVENUE STE 203, WESTMINSTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Glow & Sparle Registrar JUN 2 7 2005

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F			giene	5 22767
П	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day	3. Time of Death
	/Medic	al	Albert W. Se. 4a. Facility Name (If not institution, give			4h City Town o	r Location of Deat	June	22 20 4c. County o	005 2:24 A.M
	Examin	er	Continuum Care @	*			esville	.,		roll
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, Year) 1919	9. Birthplace (State or Foreign County) Maryland
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla f eho	to	Maryland Carro			sville				1 ☐ Yes 2 🖾 No
	h the r 28a	irec	10e. Street and Number			10f. Zip Code	-		10g. Citizen of Wi	hat Country?
	23a c	ralD	2120 Country Fa	air Lane		21	784		United	States
	er des items ner m	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (9 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	- American Indian, r, White, etc.
336	urs aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 12 No If Yes, Give Year or Dates:	'	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland Inatural', or Items 23a or 28a-f ehow deal Examiner must be neithfied at	Completed by	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup	ation	rkina	16b. Kind of Bus	
121	vithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+	life I	DO NOT use retired Judge	d)	9	Ornhans	County Court Carroll
Q 0	filled v Hygie other t	Co	12th 17. Father's Name (First, Middle, Last)			Juage	18. Mother's Na	me (First, Middle,		
lan	Aental Aental rked c	To Be	William Ewald	Walters			Bess	ie Murra	ıy	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinational Lieunitified at ODGs.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street				
e,	1 and Health em 27 ther tr		Mrs. Joan Candy 20a. Method of Disposition	Selby Wif	e 2120 20b. Place of Dispo	O Country				ID 21784 Dity or Town, State
nor	ages ant of I t: If Ite y or o'		1 № Burial 2 Cremation 3 C 4 Donation 5 Other (Specif		Wesley Fr	natory or other plac	June June	25,		ille, Maryland
Baltimore,	mit. Poartme		21. Sana ure of Funeral Service Licer		22	. Name and Addre	ss of Facility 1	212 W. O	ld Liber	ty Road 2178/
Ö	permi Depa Impo any ii		James 6	(aur)	В	urrier-Q	ueen Fun	eral Hom	e & Crem	atory. PA
L	a les		23a. Part1. Enter the disease, or com shock or heart failure. List only	plications that caused to one cause on each line			-	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
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Box	death certific e attending p id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		Ectopic pregnancy	,			of delivery
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rds	w requires been sign should be	ed by						1 🗆 ነ	res 2 12 No 3	3 ☐ Probably 4 ☐Unknown
Vital Records,	e law requ has been je 2 should	Completed						24a. Was		Vere autopsy findings available rior to completion of cause of
E R	Th ate pag	Соп						perfo 1 Yes	rmed? de	eath?
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1 of	g Phys er this eral di	n; To	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	I 3 DOA	4 Mursing r	lome 5 ☐ Resid	now injury occurre	
sior	Attending I r death. ector: After by the funer	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	n	, oar, mijury		Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not b	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	r or Rural Route Number,
_	spital		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, death	occurred at the tir	ne, date and place	e, and due to the	cause(s) and man	ner as stated.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exar	niner: On the basis of e and manner state	examination and/or in-	vestigation, in my o	pinion, death occi	urred at the time,	date and place, ar	nd due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MO		29c. Licens	•	_		(Month, Day, Year)
7	. ~		20 Name and address of access it		ath (Itom 02a) (Tur-		17172		3 DVG S	5 5007
	15 AM		30. Name and address of person who	1-6			vite 106	E(2000	bur L	प्राच्छ्य
• ,	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	-	1		73	
	Registr	ar	JUN 2 4	2005 / 2006	w # A	and a				

			For State Registrar	State of Marylar			of Health and of Death	•	_	005	22768	3
	Physicia /Medic		Decedent's Name (First, Middle, La	RHODA C.	S	STAUP		2. Date of De Month JUNE	Day	Year 2005	3. Time of Deat 8:30 A	
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Tov	vn, or Location of D	eath	4c.	County of Death		
			7335 GAITHER I				ESVILLE	t		CARROL		
L	Funeral Director		5. Social Security Number 6. S 215-20-9499 Usual Residence of Decedent	CN VIE	30 Yrs.	If Under 1 Y Months D		Hrs. 8. Date of Bin (Month, Da 3/8/1	th y, Year) 925	9. Birth Cou PENN	place (State or Fore ntry) NSYLVANI	eign LA
	/land		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Lin	nits
	Many -f sh	ţō	MD. CARROL	L S	SYKESV	/ILLE					1 ∐ Yes 2 🗖	No
	h the	Directo	10e. Street and Number			10f. Zip Co	de		10g. Citi	izen of What Cou	ntry?	
	th will		7335 GAITHER	RD.		2	1784		,	USA		
326	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show guitsel Extra directions the notitinal at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 ☐ Yes 2		(Specify Yes or No uerto Rican, etc.)	ı-	14. Race - Ameri Black, White Specify: WI		
215-0036	within 72 horens. ene. than "natural ne wed call	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual O kind of work o DO NOT use r	tone during most of	working	16b. Ki	ind of Business/Ir	ndustry	
7	filed wi Hygien ther th	Con	12	· · · · · · · · · · · · · · · · · · ·	MA	CHINE	OPERATO			OE FACT	ORY	
yland	d be ental ked c	To Be		W. CROMWELI			1	Name (First, Middle, NAOMI E.	CA:	RBAUGH		
, Mary	d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship (SANDRA L. KEEF	**				Rural Route Number			-	
more,	Pages 1 and nent of Healt out: If Item 2 iry or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Content of the Conte	20b. I Removal from State (v) ZION	Place of Dispo cemetery, creation	osition (Name in matory or other	of r place) H CEM .	Date 6/24/05	20c. Lo	ocation - City or T	own, State	
galti	permit. Pag Department Importent: f any injury o		21. Cignard of Eurorial Service Lice	nsee	22	2. Name and A	ddress of Facility	FLETCHER	FU	NERAL H	HOME	
ñ	Per		100					., WESTN				4
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Paucreat	ic Ca	ter the mode o	f dying, such as car	diac or respiratory a	rrest,	C	Approximate Interval Between Onset and Death	l.
	Examiner			Due to (or as a consec								
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):							
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ds, P.	w requires that the s been signed by th should be detache	by	Part II. Other significent conditions	contributing to death but not res	sulting in the u	inderlying caus	se given in Part I.	23e. Did to		V	the cause of death?	
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=		Be	25. Was case referred to medical examiner?	Hospital:			Other	Death (Check only o				
o	Physic rithis praidi	: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	28b. Time o		4 🗆 1401311	g Home 5 X Resident			fy)	
0	th. : After funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Injury at Work? 1 ☐ Yes 2 ☐ No			,		
DIVISION	el or Attendi safter death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not to determined	De Diago of Injury At In	nome, farm, st fy)	reet, factory, o	ffice	28f. Location (S City or Tow	Street an wn, State	nd Number or Run e)	al Route Number,	
	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	nysicien: To the best of my known in and manner stated.	owledge, deat ation and/or in	h occurred at to evestigation, in	the time, date and p my opinion, death o	lace, and due to the occurred at the time,	cause(s) date and	and manner as s d place, and due t	stated. to the cause(s)	
	To t withi To tl	M	29b. Signature and title of certifier	Paper Al Do.		29c. L	50774	MD	29d. Dai	te signed (Month,	Day, Year)	
	9 E			pleter cause of death (Ite	m 23a) (Type,	Print)	1380 Pro	MD Stess W Duly MI	04	21784		
:-	Sta		31. Date filed (Month, Ny, Xear)	005 32 Segistrar's Sign	ature A	mente						

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of l			ene 2005	22769
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, L Thomas LeRoy 4a. Facility Name (If not institution, g	Soule'		4b. City, Town,	or Location of Deat	2. Date of Death Month June 18	Day Year	3. Time of Death 3:44 p
	Funeral Director		14009 Glen High 5. Social Security Number 6.	Rd • 7. Age	e (In yrs. last birthday Yrs.	Baldw:	in If Under 24 Hrs	8. Date of Birth (Month, Day,		thplace (State or Foreign punity)
	te Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltin	ore	10c. City, Town or L Baldwin					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Moulcal Exercities at	Completed by Funeral Director	14009 Glen Hi 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 15. Decedent's (Specify only highest g	12. Was Decedent E Armed Forces? 1 GYes 2 D If Yes, Give Year or Dates:	1967 1967	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No edent's Usual Occu	pation during most of wo	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: 6b. Kind of Business	encan Indian, e, etc. White
Maryland 21	should be filed withir and Mental Hygiene. I marked other than umatic event, the Mental Men	To Be Corr	12 17. Father's Name (First, Middle, La. Louis Giles Sou	5+		ical Ther	18. Mother's Na	me (First, Middle, M Opalene W		oyed
Baltimore, Mary	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, If an once.		19a. Informant's Name/Relationship Virginia Ida Sou 20a. Method of Disposition 1☆ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Survice Lice	(Type, Print) le! — Wife □Removal from State ifly)	20b. Place of Disp cometery, cre Maryland	09 Glen I osition (Name of matory or other pla Veterans	tand Number or Relation Rd. Aigh Rd. Bis Cem 6/	Baldwin Date 2	City or Town, State, 2 MD 2101 Oc. Location - City or arrison, 1	L3 Town, State
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter in e, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Fisease or injury that initiated events resulting in death) Last	a	the death. Do not ene. a consequence of): a consequence of):	iter the mode of dy	ing, such as cardia	• Westmin		Approximate Interval Batween Onset and Death
P.O. Box 68760,	certificate Iding phys	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 time of death 5	□Ectopic pregnanc		22a Biddah	23d. Date of del Month	Day Year
Vital Records,	requires seen sign hould be	Completed by	Part II. Other significant conditions	contributing to death bu	at not resulting in the i	underlying cause gi	ven in Part I.	1 ☐ Yes 24a. Was an autopsy	24b. Were au	obably 4 Unknown topsy findings available completion of cause of
of	g Physician: The law er this certificate has t eral director, page 2 s	To Be	25. Was case referred to medical examiner? 1 Yes 2 2 No 27. Manner of Death	Hospital: † ☐ Inpatie 28a. Date of Injur		all DOA	her: 4 Nursing H	ath (Check only one	☐ 1 ☐ Yes) ice 6 ☐ Other (Spec	2 No
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification;	VXNatural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	on be on Blace of Jain	ıry - At home, farm, s	M 1	Yes 2□No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medicai ((Check only 2 Wiedical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and/or in	nvestigation, in my	opinion, death occu	urred at the time, dat	e and place, and due	to the cause(s)
	WIL		29b. Signature and title of certifier 30. Name and address of person wh	and the same of th		D3	se number 535 Y	6	d. Date signed (Month	5
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2		ir's Signature		SALTIM	ore My	12/1220	7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NZ Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12:12P M JULY 2-Clarence Carroll Smith 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1**X** M 2□ F Yrs. Director 220-24-8905 72 Sep 22, 1932 **Maryland** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or flems 23a or 28a-f show 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland St. Mary's Callaway 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20098 Piney Point Road 20620 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Owner/Operator Small Engine Repair permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Item 27 is marked other any njury or other traumatic event, SINR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Allie Fergerson Smith, Jr. Lessie Rebecca Dyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rossetta Smith P. O. Box 257, Callaway, MD 20620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda United Cemetery | July 9, 2005 | Valley Lee, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signutu e of Funeral Service License Mattingley-Gardiner Funeral Home, P.A., 22. Name and Address of Facility P. O. Box 270, Leonardtown, Maryland 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ptic da disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pancytopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mon Due to (or as a consequence of) Examiner physiclan and the burial-transit ZL LUNG Cancer The law requires that the death certificate be executed S QUAMONS Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. the ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Onknown Completed 24a. Was an autopsy performe 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 340 this 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After Division To the Hospital or Attending 5 Pending investigation 1 Natural 2 Accident death. 1 Tes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after on Funeral Direct 4 Homicide 29a. Certifier Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's 3

DR. DAVID ALLEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ST. MARY"S HOSPITAL

CLARENCE CARROLL SMITH

25230

LEONARDTOWN, MARYLAND 20650

7-2-05

			1 - State Registrar C	partment of Health and Me ertificate of Death	ental Hygiei	
	Physici /Medi	cal.	1. Decedent's Name (First, Middle, Last) Thomas Michael Smith		July 1	Day Year 3. Time of Death
	Examir Funeral	ier	4a. Facility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Hagerstown y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4c. County of Death Washington 9. Birthplace (State or Foreign Country)
	Director		178-48-0487		(Month, Day, Ye. May 11,	1957 PA
	the Mary	Director	PA Franklin Washi	ngton TWP	100	1 Yes 2 No
	h with		11892 Gehr Road	17268	log.	USA
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 ia markad othar than "natural", or Itams 23a or 28a-f ehow other traumatic event, the Medical Examination was be realised at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	3. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Fi	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho lene. 'than "natu	Completed	(Specify only highest grade completed) (Gi	pedent's Usual Docupation we kind of work done during most of work in . DO NOT use retired) Salesperson	g 16b.	Kind of Business/Industry Too1 company
ק	e filed al Hygi othar vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	*
ylaı	should be ind Mental s markad c umatic eve	To E	Paul R. Smith, Sr.		d E. Cant	
Maryland	d 2 sho th and 7 is my trauma			iling Address (Street and Number or Rural		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 i any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 20b. Place of Discemetery, c	position (Name of rematory or other place) 1 Church Cem. Jul 7 22 Name and Address of Facility Groves 50 S. Broad St., Waynes	ve-Bowers	Location - City or Town, State ashington TWP anklin Co PA BOX Funeral Home, Inc
68760,	Physician personal displaying physician and physician and physician are as the purial-transit	edical Examiner	23a. Part Anter the disease, or complications that caused the death. Do not estable or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Thauma	respiratory arrest,	Approximate Interval Between Onset and Death
O. Box	death e atter	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death? 2 2No 3 Probably 4 Unknown
Division of Vital Records,	The ate h page	e Completed	25. Was case referred to medical	26. Place of Death (24a. Was an autopsy performed?	
<u> </u>	Phyaician: this certific ral director,	To B	examiner? 1 Yes 2 □ No	Other		6 □Other (Specify)
sion o	Jing J. After fune	ertification;	27. Manner of Death 1 □ Natural 5 □ Pending 2 ☒Accident investigation 3 □ Suicide 6 □ Could not be	of 28c. injury at Work? M 1 Tyes 2 No	d. Describe how in	jury occurred Live Accident
Dİ	or At fter of Diract in by	O	4 Homicide determined 288. Photo of Injury - At nome, farm, building, etc. (Specify) 5 to the line was	R	+ 66 -N	2. Bone 00/6
	To the Hospital within 24 hours a To tha Funaral C completely filled	ledical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, de (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cause I at the time, date a	(s) and manner as stated. Indicates, and due to the cause(s)
	To To	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	18		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Typ Edward W. 21th Tarin 1901) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	e, Print) Mchard Lemair is	the the	10 8 foun, (7)
(·)	Sta Registr		31. Date filed (Month, Day, Year) 32. Redistrar's Signature	hastes		7:: 1-
		- 4	JULIIZUUD Thomas It	700		

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Amend item 7 per fh 8845 7-13-05 bt.

Amend item 7 per fh 8845 7-13-05 bt.

			1 - For State Registrer	State of Ma	aryland			it of He te of D			_	giene Reg. N2 N	በፍ	227	פדו
	Physici	* 36.	1. Decedent's Name (First, Middle, Last								2. Date of De		Year	3. Time	of Death
	/Medic		ALVERDA MAE SPA								JULY	4	2005	2:30	Рм
}	Examir	er	4a. Facility Name (If not institution, give GOODWILL MENNON)		ור שחש	TC .		, Town, or l GRANT					nty of Deat RETT	h	
	Funeral	6	5. Social Security Number 6. Se	7. Age	e (In yrs. las		If Unde	r 1 Year	If Under	24 Hrs	8. Date of Bir	the .	0.0:-	hplace (State	or Foreign
	Director		21/ 14 4240	M 2 □ NF	85	Yrs.	Months	Days	Hours	MIN.	MARCH 4	1920	MZ	ARYLANI)
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
	Many -f sh	jo l	MARYLAND ALLEGANY			FRO	STBU	RG						1 ☐ Ye	s 21 No
-	or 282	Olrec	10e. Street and Number				10f. Zi	p Code				10g. Citizen o	of What Co	untry?	
	s 23s	ral	17104 SPATARO LANE					215					S.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep irrpent of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any njury or other traumetic event, it's W. dical Examinar must be notified at 20cs.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced	12. Was Decedent (Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 ☐ Yes	cify Cuban	panic Orig , Mexican Specify:	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)		lack, White	nican Indian, e, etc. VHITE	
21215-0036	2 hou	ted	15. Decedent's Edu	cation		16a. Dece	dent's Usu	al Occupat	tion			16b. Kind of	Business/	Industry	
215	ithin 7 19. 18. "n	Completed	(Specify only highest grad	College (1-4or 5	i+)	life.	DO NOT L	ork done du ise retired)	ırıng most	t of worki	ng				
	illed w Hygier other th		10 17. Father's Name (First, Middle, Last)			Н	OMEM		19 Motho	r's Nama	(First, Middle,		MOH I	E	
Maryland	id be f ental k ked of ic ever	To Be	RALPH S. STU	RTZ							O. TRO		ame)		
lary	2 should and Men Is marke sumetic	-	19a. Informant's Name/Relationship (T)								I Route Numbe				
	1 and Health am 27 thar tr		JOHN SPATARO / SON		20h Blad	1261 ce of Dispo			TER F		CUMBE				
Baltimore,	Pages pent of h int: If its iry or of		tX Burial 2 ☐ Cremation 3 ☐ F		cen	netery, crer	natory or	other place	· I			20c. Location WELLEI	•		
	outroe outan injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		COOK	CEME		nd Address		7/7/(y	J5			STREE'	т
ä	permit. Departrimports any inji		Y Corloy 1)	Sower	V	S	OWERS	FUNI	ERAL	HOME	E, P.A.				_
-0			23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused ne coup on each lin	the death.	Do not ent	er the mo	de of dying,	, such as	cardiac o	r respiratory a	rest,		Approxima Interval Be	tween
	Pnysician /Medical	i li	Immediate Cause (Final disease or condition resulting in death)	Colon	Ca	nce	N							Onset and	205
	Examiner			Due to (or as:	a conseque	nce of):	111		Har	110	cont	. 0.	,	Court	<
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):	we		11		cyph	un)	J	3
V	ecuted and -transi	Examin	Cause (Disease or injury	Due to (or as		200 200									
8760,	cate be executed physician and the burial-transit	ia E		D00 10 (0) as i	a consaqua	nce or).									
687		edlcal		J								1,5			
Вох	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	Zob. Was decadent pregnant	3c. If yes, outcome 1□Live birth			Ectopic p	regnancy					Date of deli	,	
O. E.	ne dea the at thed fo	ysici	in the past 12 months? 1 □ Yes 2 ┗ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of dea		Other (s						Month	Day	Year
٥.	that the	/ Ph	Part II. Other significant conditions co	ntributing to death bu	ut not resulti	ng in the u	nderlying	cause giver	n in Part I.		23e. Did to	obacco use co	ntribute to	the cause of	death?
Records,	w requires been sign should be	ed by									101	es 2 140	3 □ Pro	obably 4]Unknown
eco	e law requ has been je 2 shoult	Completed									24a. Was		. Were au	topsy findings	available
	10 -	Con									perfo 1 ☐ Yes	med? 212 No	death? 1 ☐ Yes	_/	
Vital	ding Physician: Th h. After this certificate funeral director, pag	o Be	25. Was case referred to medical examiner?	lospital:				Other	- /	-	(Check only o				
o		I	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	nt 2 EF	8b. Time of		28c. Injury a	at Pivui		ne 5 🗌 Resid 28d. Describe h			eity)	
ion	ttending F death. ctor: After y the funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y rear)	Injury	М	Work? 1 ☐ Ye	es 2 🗆 h	No					
Division	Pospitel or Attend 24 hours after death 5 Funeral Diractor: 81ely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At hom c. <i>(Specify)</i>	e, farm, str	eet, factor	y, office		2	28f. Location (5 City or Tox	Street and Num m, State)	nber or Ru	ral Route Nur	nber,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Diractor; After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best oner: On the basis of and manner sta	examination	edge, death n and/or in	occurred vestigation	at the time	e, date and nion, deat	d place, a	and due to the	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
	To the Vithin 2: To the Complet	Me	29b. Signature and title of certifier	0	67	7	29	c. License	number			29d. Date sign	ed (Month	, Day, Year)	
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	\		30. Name and address of person who co	ompleted cause of de		3а) (Туре, Z-Ч /	Print)	les	<+		vani	L. 1	101	20	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	0			ار_	9	veni	SVII	15,1	د ۱۲۰۰	
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	1 _ For State		State of	Maryland /	Department of Certificate o		Mental Hy			
	Registrar 1. Decedent's Name (Fin.	st, Middle, La	st)		Och incate o	Douin	2. Date of De	Reg. No	005	23. Trime of Death
cian	George	На	arry	Small	wood		June 2	7, ^{Day}	005 Year	7:10 PM
dical niner	4a. Facility Name (If not	institution, giv	e street and numb	ber)	4b. City, Town	, or Location of Deat			County of Dea	th
	St. Mary	's Nur	sing Cen	ter	Leon	ardtown		S	t. Mar	y's
al or	5. Social Security Number 570-34-0816		ex M 2□ F	. Age (In yrs. last bi	irthday) If Under 1 Yea Months Day		8. Date of Bir (Month, Da Nov . 10	th Year)	C	thplace (State or Foreig puntry) ryLand
	Usual Residence of Deci	edent c. County		10c. City, Tov	vn or Location					10d. Inside City Limit
ţ	Maryland S	St. Mai	rv's	Но	11ywood					1 □ Yes 2 N
Director	10e. Street and Number				10f. Zip Code	9		10g. Citize	en of What Co	ountry?
a D	23875 Tin	Top H	ill Lane		20	636		U	S A	
Funeral	11. Marital Status		12. Was Deced	ent Ever in U.S.	13. Was Decedent of	of Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or No o Rican, etc.)	D- 14	4. Race - Ame	
þ	1 Never Married 3 Widowed 4		1 XYes 2 If Yes, Give Year or Date	No	1 ☐ Yes 2 🝱 N				Specific	Black
etec		Decedent's Ed	ducation ade completed)	16a	a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	cupation ne during most of wo	rking	16b. Kind	d of Business	/industry
Completed	Elementary/Secondary 5	y (0-12)	College (1-4	4or 5+)	Laborer			Civ	vil Se	rvice
To Be (17. Father's Name (First) Joseph	t, Middle, Last,		llwood		18. Mother's Nar Mary	ne (First, Middle	_	_{Sumame)} ears	
	19a. Informant's Name/I	Relationship (Type, Print)	19	b. Mailing Address (Stre	eet and Number or Ru	ıral Route Numb	er, City or	Town, State,	Zip Code)
	Estelle Sm		l/Wife		3875 Tin To					
	20a. Method of Dispositi	ion							-Ai Cia	Tours State
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attention 24 hours after death within 24 hours after death To the Funerel Director:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number
D 5 1 738 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD

DEAN RD. HOLLY WOOD, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAE T. AUNG 24435 MERVELL

31. Date filed (Month, Day, Year)

32. Registres Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Ernest Lawson STINE 29 2005 2:25 a. m. June /Medical 4b. City. Town, or Locetion of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Julia Manor Nursing Home Hagerstown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1**X**□M 2□F Yrs. Director 220**-**05-6571 June 4 1918 Maryland Usuel Residence of Decedent filad within 72 hours eftar daath with tha Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Funeral 21740 U.S.A. 933 Corbett Street 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Armed Folkes.
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: ₩₩ 11 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: Š 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry pamit. Pagas 1 and 2 should be filad within Dapartmant of Haalth and Mantal Hygiana. Important: If Itam 27 ia marked other than 'any injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 8 Sheet Metal Aircraft Manufacturer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Ellen Poffenberger Samuel Lawson Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Leona S. Stine - Wife 933 Corbett Street, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/2/05 Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Hagerstown, Maryland 21740 415 E. Wilson Blvd. aleut W. Ka 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and s tha burial-transit or Attanding Physician: The law requires thet the deeth cartificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 00 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 27 No this 28b. Time of Injury 27. Menner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 DNaturel daath. 1 ☐ Yes 2 ☐ No 2 Accident eftar daath Director: / in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide • Funaral Di letely fillad in t⊈ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier To the To the To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/29/00 22 44 015753 6+1VA 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 1126 Opal Court, Hagerstown, Md. 21742 M. Khalid Waseem

Registrar **DHMH 16 Rev 6/95**

21215-0020

Baltimore, Maryland

Box 68760.

P.0.

Records,

Division of Vital

32. Segistrar's Signature

			For State Registrar	State of Mar	•	artment of H			ene = N2 () () [20776
			Decedent's Name (First, Middle,)	Last)		Timodio or E	-	2. Date of Death		ل_	3. Time of Death
	Physici /Medic		Delores	Elaiı	ne	SHANK		Month	Day	Year	-1:07 M
	Examin		4a. Facility Name (If not institution,				Location of Death		4c. County		
			Washington Coun			Hagerst			WASH	INGTO	
	Funeral Director		5. Social Security Number 218-24-1638	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sep. 25,	1929	9. Birthp	ace (State or Foreign try)
			Usual Residence of Decedent					3ep.25,	1929	мат у	ranu
	ryland		10a. State 10b. County	1	Oc. City, Town or Lo	ecation				1	Od. Inside City Limits
	Ba-1 s	by Funeral Director	MD Washin	gton	Hagersto			·			1 ☐ Yes 2 XNo
	with the or 2	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of V	What Coun	try?
	eath 1 18 23(eral	11123 Lakeside	12. Was Decedent Ev	er in U.S. 13		740	ecify Yes or No-	USA 14 Bac	e - Americ	an Indian
(0	r Item	Fun	1 Never Married 2 Married	Armed Forces? d 1 □ Yes 2 No		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)		k, White,	
8	ours a	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify	· Whi	te
21215-0036	within 72 hours after death with the Maryland one. then "natural", or Items 23a or 28a-1 show the Modical Examiner must be notified at	Completed	15. Decedent's (Specify only highest		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing 16	6b. Kind of Bu	usiness/înd	lustry
12	within ane. than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	Home)		Home	0	
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	CO	8th 17. Father's Name (First, Middle, La	ist)	11011101		18. Mother's Name	e (First, Middle, Ma			
Maryland	should be nd Mental marked o	То Ве	Abraham	(nmi)	Dec	eds	Alice	(pr	mi)	т	roxell
lary	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 le marke any injury or other traumatic once.	-	19a. Informant's Name/Relationship			ng Address (Street a					
	1 and 2 Health em 27		Robert S. Shank	Sr. (husband		3 Lakeside					
lore	Pages 1 a nent of Hes int: If item iry or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	□Removal from State	-	matory or other place	θ)		Oc. Location -		
Baltimore,	permit. Pages Department of I Important: If itt any injury or o		' 4 ☐ Donation 5 ☐ Other (Spe 21. Signatur — Speral Service	ecify)		l Cemetery		7,2005 Ha	agersto	own,	MD 21740
Ba	permi Depa Impo any ir		21. Signature to danati Service	1/1/0-	0	BORNE FULL	NERAL HOM	E 64 M:			ND 04705
			23a. Part1. Enter the disease, or co	omplications the caused the		25 S. Conder the mode of dying	ococheagu g, such as cardiac	or respiratory arres	it∕.	JOPT.	Approximate
	Frysician		shock, or heart failure. List or Immediate Cause (Final	HWA	ueed.	ABDO 11	WAL I	aurer	Kera	-	Interval Between Onset and Death
	/Medical		disease or andition resulting in leath)	a	consequence of):	0 1 00 1 100	111 1		Λ	-	defi
В	Examiner		Sequentially list conditions,	b. 11N1211	vs sque	ruous ce	ll Car	emora	"		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	onsequence of):	60					
	xecut and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
8760,	cate be executed obysician and the burial-transit	ical		d							
9	rificat ng phy as th		15.55.111.5								
Вох	death certific e attending pl od for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Dat	e of delive	ry Day Year
_	ne dea the at hed fo	/slcl	1 \(\superset \) Yes 2 \(\superset \) No 9 \(\superset \) Unknown	4□Pregnant at tir 9□Unknown	ne of death 5	Other (specify)			INIO	11011	Day Teal
P.0	law requires that the de as been signed by the 2 should be detached			stoning to death but	not resulting in the u	nderbying dause give	en j r Part I.	23e. Did toba	icco use contr	ribu <u>te to th</u>	a cause of death?
Records,	puires n sign ald be	d by	JAMELS NE	Ullis, Ce	ronary	arley	Resease	1 ☐ Yes	2 1 No	3 □ Proba	ably 4 Unknown
00	s beel	Completed	- lunuteu.	sion. 1	wol/	worth	ueuce)	24a. Was an	24b. V	Nere autor	osy findings available
æ	The lav	omo			1//	1		autopsy performe	8d?	leath?	npletion of cause of 2□ No
Vital	sien: artifica ctor, p	Be C	25. Was case referred to medical examiner?		· ·		26. Place of Death	(Check only one)			
of V	Physicien: r this certific ral director,	2	1 Yes 2 ₩	Hospital: 1 Inpatient			4 Norsing no	me 5 Residen)
on C	Jing F	:lon:	27. Manner Teath 1 Latural 5 Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time o	Work	rat ⟨? Yes 2. □ No	28d. Describe how	injury occurr	ed	
Division	l or Attending after death. Director: After I in by the fune	ficat	2 Accident investiga 3 Suicide 6 Could no	t be 22. Place of Injury	r - At home, farm, st			28f. Location (Stre		er or Rurai	Route Number,
<u>S</u>	after s after I Dire	Certification:	4 Homicide	building, etc.	(Specify)	, ,		City or Town,	State)		
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying (Check only 2 Medical E)	Physician: To the best of examiner: On the basis of ex	my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the cau	ise(s) and ma	nner as sta	ated.
	To the H within 24 To the F complete	Medical	one)	and manner state	d.						
	To To cor	-	29b. Signature) and title of certifier	The mo		29c. License	6CC	290	d. Date signed		
,			30. Name and address of person w	to completed cause of dos	th (Item 23a) (Type	Print)	622	00	NE d	7/	Loog
4-	2		324 Eur An	Tigtom SI	rest. fo	Te 200.	HAZUS.	trun, M	10) 2	114	0
	Sta		31. Date filed (Month Pay, Year)	2005 32. Registrar's	s Signature	1.1.		/			
	Registi	ar	30N & 0	Lucy	~ D. P.	nese					

		1	For State Registrar	State of N	Marylan		artmen rtificat			and M	lental Hy	giene Rog. ND	105	22776
	siciar edica		Decedent's Name (First, Middle, Lass WILLIAM EDWARD ST	EWART							2. Date of De Month JULY 1	, 2005		3. Time of Death 9:15 A
	mine		4a. Facility Name (If not institution, give 1286 LIMPOPO LANI 5. Social Security Number 6. S	E		last birthday)		ENRY	Location of		8. Date of Bi	GA	RRETT	
Fune: Direct	tor		198-24-8296 Usual Residence of Decedent	MA OF	72	Yrs.	Months	Days	Hours	Min,	8. Date of Bir (Month, Da JULY	ay, Year) 9, 1932	2 PA	hplace (State or Foreig nuntry)
ath with the Marylan s 23a or 28a-f show			10a. State 10b. County MD GARRETT			y, Town or Lo	Y							10d. Inside City Limits 1 ☐ Yes 2X No
with t		<u></u>	10e. Street and Number 1286 LIMPOPO LANE	7			10f. Zip	2154	1			10g. Citizen		ountry?
er de	7	by runera	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	?] No	-1		dent of Hi		gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	0- 14.	Race - Ame Black, Whit	rican Indian, e, etc. THITE
ZTZT5 d within 72 jiene. r than "na	potolean	ompleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		r 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us REPA	rk done d se retired	luring mosi)	of work	ing		of Business/	
Viand 2 Juid be filed Mental Hygic arked other attic event, in	á	9	17. Father's Name (First, Middle, Last) AARON THOMAS ST	EWART					18. Mothe		(First, Middle	JONE		
			19a. Informant's Name/Relationship (1 MARGARET A. STEWA			1286	LIMP	OPO		M	ICHENRY	, MD 2	1541	
Page Page ment o			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	•)	е с	Place of Dispo cemetery, cren EGA CRE	MATOF	ther place RY		7/2/	05		ion - City or ANTOWN	Town, State
permit. Departr Imports	once.		21. Signature of Funeral Service Licen	Just	M001	1	URST				P.O. - OAKL	BOX 2 AND, M		50
rate be executed xx xx xx xx xx xx xx xx xx xx xx xx xx	al ler	LYG	shock, or heart failure. List only is Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c. Due to (or a d.	PRO	uence of):	C CA	M	ETAST	ASIS				Interval Between Onset and Death YEARS
death certific e attending p	Joh/Mod	iyəlcidi izinde	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic pro					23d.	Date of deli Month	very Day Year
law requires that the as been signed by the 2 should be detached	ì	בַּ	Part II. Other significant conditions co	ontributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.					the cause of death?
The The ate has page	2	naidillo.	·····					-		_	24a. Was auto perfo	psy ormed?	4b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of
Physiclan: The this certificate ral director, pag	a	מ	25. Was case referred to medical examiner?	14						of Death	(Check only o			
Attending Physic death. ector: After this of the funeral dir	-		1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		Bc. Injury Work	4 🗆 Nu	- 2	ne 5 X Resi 28d. Describe			eify)
i Site	Cartification.		3 Suicide 6 Could not be determined	286. Place of II	njury - At ho	ome, farm, stre	eet, factory	, office		1	28f. Location (City or To	Street and Ni wn, State)	umber or Ru	ral Route Number,
To the Hospital within 24 hours a To the Funeral t completely filled	ledical	calical	29a. Certifier Contifier Check only one)	ysician: To the bes liner: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
To T	2	2	29b. Signature and title of certifier	7 —				License				29d. Date sig		
			30. Name and address of person who o				Print)	H261.	0 4				1, 200	
	State		P. DANIEL MILLER, 31. Date filed (Month, Day, Year)		69 T trar's Signa	WOLF AC	CRES]	DK.			OAKLAI	ND, MD	21550)
	istrar			2005	telesco	15	Joseph	E W						

			For State	State of Mary		rtment of Healtl tificate of Dea		• •		00777
			1. Decedent's Name (First, Middle, La	ast)	Cer	tilicate of Deal		Reg.	£005	3. Time of Death
	Physicia /Medic		Mae B. Sisler				8.4		^{Day} 2005 Year	1:30 A M
	Examin	100	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Location	on of Death		4c. County of Dea	
			Garrett County N			Oakland If Under 1 Year If Und	der 24 Hrs. 8 D	ne of Dist	Garret	
	Funeral Director		214-80-0111	Sex 7. Age (III	n yrs. last birthday) Yrs.	Months Days Hou	rs Min. (A	ate of Birth fon <i>th, Day, Ye</i> Ly 10,		thplace (State or Foreign ountry) yland
	/land		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	e Man	ctor	MD Garre	tt		Oakland				1X Yes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	eath v	Funeral	400 Glades West	, Apt. #8	rin U.S. 13 V	2155 Vas Decedent of Hispanic		es or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturet", or items 23a or 28a-f show any njury or other treumstic event, the Medical Examiner must be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuban, Mex □ Yes 2 X No <i>Spec</i>	ican, Puerto Rican	, etc.)	Black, White	te, etc.
21215-0036	2 hou	ted	15. Decedent's E	Education	16a. Deced	lent's Usual Occupation		16b	. Kind of Business	/Industry
2	ithin 7 nen "r	Completed	(Specify only highest g	College (1-4or 5+)	life. L	kind of work done during n DO NOT use retired)	nost of working			
	filed w Hygier other th	Co	7 17. Father's Name (First, Middle, Las	et)		Homemaker 18 M	other's Name (Firs	t Middle Maid		Home
au	ld be lental l	To Be	Benjamin Keller	,			maline Bo		on Jamame)	
Maryland	shou and M is mar		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street and Nu	mber or Aural Rou	te Number, Ci	ty or Town, State,	Zip Code)
	1 and 2 Health a tem 27 i		James Sisler, S			alvert Court		-		
Baltimore,	ages 1 nt of H : If ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	Removal from State		natory or other place)	Date		. Location - City or	
븚	artmer ortent njury		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 			k Cemetery, Name and Address of Fa			Accident	•
Ba	Departiment in portion and in portio		19 Luc)lerna	179	Miller St,	PO Box 2	75, Gra		, MD 21536
			23a. Part1. Enter the disease, or conshock, or heart failure. List onto	y one cause on each line.	e death. Do not ent	er the mode of dying, such	n as cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Pneu Due to (or as a c	monia					2 Weeks
8	Examiner		Conventingly list conditions	200000000000000000000000000000000000000	Carrier Street Control Are	ory Failure				Years
+	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe or injury	Due to (or as a c	onsequence of):					
	xecute and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):					
68760,	licate be executed physician and s the burial-transit	edicai E		d						
_	ertitica ling ph e as th		IF FEMALE:						II.	
Вох	attenc attenct for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1□Live birth 2 [4□Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
o.	t the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ie or dealtr 3	Culer (specify)				
ds, P	law requires that the death certit as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions		ot resulting in the u	nderlying cause given in Pa	art I. 2	23e. Did tobacc		o the cause of death?
CO	aw requir 1s been si 2 should	iete			1001			4a. Wasan	24b. Were at	utopsy findings available
Vital Record	The lay ate has bage 2	Completed						autopsy performed Yes 2	prior to death?	completion of cause of
/ital		Be C	25. Was case referred to medical examiner?			26. P	lace of Death (Che			
of \	Physicien: rthis certitic ral director,	P.	1 ☐ Yes 2 ☐ No 27. Man of Death	the second second	2 ER/Outpatien				6 Other (Spe	ecify)
	th. : After	tion	Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Yoon	ear) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2		Describe how in	rijury occurred	
Division	or Attenation	Certification:	3 Suicide 6 Could not determine	be 290 Bloco of Injune	- At home, farm, str Specify)	eet, factory, office		ocation (Street lity or Town, St		ural Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely tilled in by the funeral.	edicai Ce	(Check only 2 Medical Exa	Physician: To the best of raminer: On the basis of ex	amination and/or in	n occurred at the time, date vestigation, in my opinion,	e and place, and d	ue to the cause the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	o the o the omplel	Med	one) 29b. Signature and title of retifie	and manner stated	1.	29c. License numb			Date signed (Mont	
)	P S P Ö		+1	olum		D12	333		(a/27	105
			30. Name and address of person when Thomas Johnson,				land. MD	21550	,	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		DELECT Oak	raid, FID	21330		
	Registr		1011 - 1	2005	. B. A.	market 1				

		1	For State Registrar	State of Maryl	•	artment of H			giene	700	22778
			Decedent's Name (First, Middle, Last	it)				2. Date of De	ath		3. Time of Death
Phy:	sicia			•				Month	Day	Year 105	12.05 A M
	edica		Nola Evonell Tel 4a. Facility Name (If not institution, give			4b. City. Town, o	or Location of Death	June 25		County of Dea	12:05 A
Exa	mine	1	×			Cilvon	Canina		м	ion t com	3.34 × 7
	1		Fox Chase Rehab. 5. Social Security Number 6. S		yrs. last birthday)	Silver If Under 1 Year	If Under 24 Hrs.	8. Date of Bil (Month, Da	th	ontgome 9. Bir	thplace (State or Foreign ountry)
Fune Direct				□M 21/2 F	71 Yrs.	Months Days	Hours Min.	Mar. 21	19, Year)	4 Ker	ntucky
	.01	-	Usual Residence of Decedent			1			,,,,,,		
/land	1		10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
Man)		ğ	Maryland Montgom	ory	Silver	Spring					1 ☐ Yes 2 🙀 No
the 288		- I	10e. Street and Number	ery	DILVEI	10f. Zip Code			10g. Citi	izen of What C	ountry?
with 38 of			1702 Glen Karney	Place		20	902		US	Δ	
be filed within 72 hours after death with the Maryland tal Hyglene. And other than "neturel", or items 23s or 28s-1 show worth		_	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of I	Hispanic Origin? (S	pecify Yes or N		14. Race - Am	
fler	- E	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No			an, Mexican, Puert	o Rican, etc.)		Black, Whi	te, etc.
urs a		ě	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 195	52-53	1 ☐ Yes 2½ No	Specify:			Specify: Wh	nite
2 ho		Completed	15. Decedent's Ed	lucation	16a. Dece	edent's Usual Occur kind of work done	pation	deina	16b. Ki	ind of Business	/Industry
7 nic		be	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of wor d)	Killy			
i wit		E	12	osnogo (* ********/	Home	emaker				Own Hor	ne
eth g	i i	BeC	17. Father's Name (First, Middle, Last,				18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)	
ld be wed		2 B	Melvin Irick				Elizabe	eth Ra	ıv		
shou M M			19a. Informant's Name/Relationship (19b. Mail	ing Address (Stree			er, City o	r Town, State,	Zip Code)
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Improvement: If item 27 is marked or other than "neturel; or items 23s or 28s-f show visions or some standard or the standard or some standard or the standard or			Kathryn A. Rugger	io Daughter	· 17 Bı	ıttermilk	Drive	New Wir	dsor	. New '	York 12553
Head H	0		20a. Method of Disposition	2	Oh Place of Disn	osition /Name of		Date		ocation - City o	
of of of of			1 Burial 2 Cremation 3	Removal from State	ower Tus	ematory or other pla carora	1 7	27 2005			
mit. Peges partment of portent: If it	5		*4 □ Donation 5 □ Other (Special 21. Signature of Juneral Service Lice)			erian Chi		27,2005	Acad	emia, P	ennsylvania
Depa mpo	once.		21. Signature of Furieral Service Lice	000	F	rancis J.	Collins	Funeral	Hom	e, Inc.	
- 40-			23a. Part1. Enter the disease, or com	A Cole		00 Univer				Spring	MD 20901
			shock, or heart failure. List only	one cause on each line.	death. Do not er	iter the mode of dy	ing, such as cardia	c or respiratory i	211031,		Interval Between Onset and Death
Pnysic	iai i	1	Immediate Cause (Final disease or condition	Congesti	ve Heart	Failure					3 months
/Medi	_		resulting in death)	Due to (or as a co	nsequence of):						
Examir	ner		Sequentially list conditions,	b. Coronary		Disease					1 year
D :		ner	if any, leading to immediate Cause (Disease or injury	Due to (or as a co	nsequence of):						
the attending physician and	rans	Examine	that initiated events	c							
a exe	-la	EX	resulting in death) Last	Due to (or as a co	insequence of):						
te be e	9	dicai		_ d	·						
ulficat tificat ng phy	as	led							1	-	
BOX OF BOATH	nse	S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□Ectopic pregnane	ev			23d. Date of de	
death death	0	Cia	in the past 12 months?	4☐ Pregnant at time		Other (specify)	,			Month	Day Year
j the state of	ache	Physician/Me	9 Unknown	9□ Unknown							
v requires that the de	a det	by P	Part II. Other significant conditions			underlying cause g	iven in Part I.				to the cause of death?
requires een sign	ğ	D D	Diabetes Mellity	s, Hyperten	sion,			1 🗆	Yes 2	□No 3□F	Probably 4 🗷 Unknown
w requires	shou	Completed	Chronic Obstruct	ive Lung Di	sease			24a. Wa		24b. Were a	autopsy findings available
The law	98 2	m				 		per	opsy formed?	death?	completion of cause of
VICAL T iclan: Th certificate	r, pa			I			00 Di(D-	ath (Check only	2 🔀 No) 1 1 Ye	es 2 No
Oi VItal Physician: T	rector,	Be	25. Was case referred to medical examiner?	Hospital:	- C 5010 · · ·	0	thor			C [] (0abas (0a	
hy his	9	To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpati	BILL STI DOX	4 Autorsing	Home 5 Res			ecity)
ding P h. After t	uner	lon	1 X Natural 5 ☐ Pending	(Month, Day Ye		W	ork? ☐Yes 2☐No			,	
SIC tend fleath for:	the	Certification:	2 Accident investigated 3 Suicide 6 Could not		At home form			28f Location	(Street au	nd Number or i	Rural Route Number,
DIVISION I or Attending after death. Director: Afte	in by	E	4 Homicide determined			street, factory, office	,		own, State		Tarat i Touto i Tarat i
UIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: After	pel			7	be as 1 d	ath and and a	time data and a	and due to the	2.00::/	1) and	as stated
dosp 4 hou	ely fi	ca	(Check only Medicel Exa	hysician: To the best of m miner: On the basis of ex	amination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time	e cause(s e, date an	d place, and di	ue to the cause(s)
To the Hospital within 24 hours a To the Funeral	completely filled	Medical	one)	and manner stated		290 Licos	nse number		29d Da	ate signed (Mo	nth. Day. Year)
or ¥ or	CO	2	29b. Signature and title of certifier			25G. LICEI	D28656			June 25	
10+	1		page -								
(0)			30. Name and address of person who				043	Control	BAT	20010	
			Ravi Passi, M.D				, Silver	spring,	מאו	20310	
	Sta	ite	31. Date filed (Month, Day, Year)	A Registrar's	Signature	race					

			1 - For State Registrar	State of Ma			tment of F		Mental Hyg	giene 2005	22779
		П	Decedent's Name (First, Middle, I	ast)				-	2. Date of Dea	ith	3. Time of Death
	Physici /Medio		Ethel	Bishop	To1	ber	t		June	21 2005	1 / 1 / A A M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	Location of Dea		4c. County of D	
			Calvert Memoria					Frederi		Calve	rt
	Funeral			1□M 257F	e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. E	Birthplace (State or Foreign Country)
_	Director		217–68–9588 Usual Residence of Decedent	21	89	113.			July 2	3, 1915 '	Virginia
	yland		10a. State 10b. County		10c. City, Town	n or Loca	ation			····	10d. Inside City Limits
	a-fs	ctor	MD Calver	t			Barstow				1 ☐ Yes 2 ☐ No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	ath w	rall	3725 Hallowing			,	2061	0		USA	
	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces?		13. Wa	as Decedent of H res, specify Cuba	ispanic Origin? (in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race · Al Black, W	merican Indian, hite, etc.
336	d within 72 hours after death with the Maryland plene. I then "neturel", or Items 23a or 28a-1 show I to Medical Evarigher must be notified at	by F	3 X Widowed 4 □ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	40	10	□Yes 2X No	Specify:		Specify:	hite
21215-0036	72 hou		15. Decedent's	Education	16a.	Decede	nt's Usual Occup	ation		16b. Kind of Busine	
218	within 7 ene. then "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	+)	life. DC	nd of work done of NOT use retired	during most of w	orking		
2	e filed with It Hyglene. other ther vent, the N	Con	7		hc	omema	aker			own hor	ne
and	0 5 D 0	Be	17. Father's Name (First, Middle, Las					18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
Maryland	2 should be and Mental Is marked aumatic ev	²	Henry Wesley 19a. Informant's Name/Relationship			Mailing	Address (Caraca	Lione	N15-1 N-1	0: 7 0::	Phillips
Ma	요든다ㅋ		Marie T. Hatcher							r, City or Town, State	, Zip Code)
ē,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	, daugnter	20b. Place of	Disposit	ion (Name of		gtown, M	20639 20c. Location - City	or Town, State
altimore,	Page lent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec				itory`or other plac emetery	´ l	-07-2005	Barstow	MD
alti	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service Lic	ensee			Name and Addres		07-2003	Jais COW,	PID
<u>m</u>	89 = 9	1	William	K (no		Ra	usch Fw	neral Ho	me, P.A.	Owings,	MD 20736
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lir	the death. Do no.	not enter	the mode of dyin	g, such as cardia	ac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cerel	oro Vav	scu	lan	ace	ident		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):					-8H13
	ef.	-	Sequentially list conditions,	b. Due to for as	STOSCU.	1776	v)				
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,	.,	,					
ó	exec an an rial-tr	Еха	resulting in death) Last	Due to (or as	a consequence of	of):					
68760,	ficate be executed physician and s the burial-transit	edical		d							
_	entifica ling pl		IF FEMALE:								
Вох	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 poinths?	23c. If yes, outcome	2 Fetal death		ctopic pregnancy			23d. Date of o	elivery Day Year
P.O.	he de	ysic	in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknow	4□Pregnant at 9□Unknown	time of death	5 🗆 C	Other (specify)			, world	Day Foa.
	The law requires that the tee has been signed by th bage 2 should be detache		Part II. Other significant conditions	contributing to death bu	ut not resulting in	the und	erlying cause give	n in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
Division of Vital Records,	quires n sign	ed by	Respisation	Failure					1 □ Ye	es 2 □ No 3 □	Probably 4 Unknown
000	aw requir	plete	upper and	very ble	eding	1			24a. Was a		autopsy findings available
R	The lay	Completed			9				autops perform	ned? death'	completion of cause of
ita	sian: artifica ctor,	Bec	25. Was case referred to medical examiner?				-	26. Place of De	ath Check only on	1	3 2010
7	hysic this co	2	1 ☐ Yes 25 No	Hospital: 1 Inpatie			3□ DOA Othe	4 Nursing	Home 5 Reside	ence 6 Other (Sp	ecify)
u C	ling F	lon:	27. Manner of □eath 1 X Natural 5 □ Pending	28a. Date of Injur (Month, Day		ime of njury	28c. Injury Work		28d. Describe ho	w injury occurred	
Sic	death ctor: y the	Icat	investigati 3 ☐ Suicide 6 ☐ Could not	be 200 Place of Iniv	iny - At home, far	rm etrop		es 2 □No	28f Location (St	reet and Number or I	Burni Bauta Alimbar
<u>≥</u>	after Direction	Certification:	4 Homicide determine	building, etc	. (Specify)	iii, siiee	i, lactory, office		City or Town		Hurai Houte Number,
	papite hours merel y filled		29a. Certifier 1 Certifying F	hysician: To the best of	of my knowledge	, death o	ccurred at the tim	e, date and plac	e, and due to the ca	ause(s) and manner	as stated.
	To the Hospitel or Atte ding Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and	d/or inves	stigation, in my op	inion, death occ	urred at the time, da	ate and place, and de	ue to the cause(s)
	with To t	Σ	29b. Signature and tille of certifier	Aleman = 1 1	A 4 A		29c. License			9d. Date signed (Mor	nth, Day, Year)
)				Moment	- M			02718	9	6/21	105
315.00	2		30. Name and address of person who ZAHIR YOUS	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	^ 0 -		000	Princ	e Freder	ich MO	20678
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	s Signature	/		11.71	- I IEUWO	LL / 11/1	206/0
7	Registr	ar	31. Date filed (Month, Day, Year)	2 2005 > 6	bere !	K	Costs				

			For State Registrar	State of M	aryland / Dep	partment of He <i>rtificate of L</i>			eg. 2.005	22780
	Dhusisi		1. Decedent's Name (First, Middle					2. Date of Deat Month	th Day Ye <i>a</i> r	3. Time of Death
	Physici /Medio		LEONARD	LEE TE	EAMER.	JR.		06	20 2009	5 110/PM
	Examir		4a. Facility Name (If not institution				Location of Death		4c. County of Dea	
					PITAL			0735		GEURGES
	Funeral Director		5. Social Security Number	6. Sex. 7. A	ge (In yrs. last birthda Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 05 M	hplace (State or Foreign
			Usual Residence of Decedent				10	(i) 20	05 MA	RYLAND
	ylanc how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-1 s	ctor	Maryland Prince	George	Clint	on				1 ☐ Yes 2 √ No
	th the)ire	10e. Street and Number			10f. Zip Code	00705	1	0g. Citizen of What Co	ountry?
	23a	by Funeral Director	6303 Buckler Ro	ad			20735		USA	
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces	?	I. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	γF	1 🕅 Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes Ž (X No	Specify:		Specify: B1	ack
21215-0036	hour furat	edt	15. Decedent	Year or Dates:	16a Dec	edent's Usual Occupa	ation		16b. Kind of Business	
5	in 72 n "na	Completed	(Specify only highes	t grade completed)	(Gir	re kind of work done d DO NOT use retired,	turing most of working	ng	TOD. KING OF BUSINESS	industry
212	with piene r tha	E O	Elementary/Secondary (0-12)	College (1-4or		None			None	
פַ	e filec of the vent,	Be C	17. Father's Name (First, Middle, I	_ast)	1-,,,_		18. Mother's Name	(First, Middle, I	Maiden Sumame)	
<u>la</u>	uld b Vents rrked tic e	ToE	Leonard Lee Te	amer, Sr.			Valencia	Lasha 1	Brown	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at ODGe.	·	19a. Informant's Name/Relationsh						City or Town, State, 2	Zip Code)
Σ.	and salth n 27		Valencia L. Bro	wn/Mother		Buckler			20735	
Baltimore,	of H of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State		ematory or other place	e) D	ate	20c. Location - City or	Town, State
Ē	Pag ment tant: jury c		`4 □Donation 5 □ Other (Sp	pecify)	Kalas Ci		6/24/0		Edgewater,N	1D
3all	Departimonic Important in Sun		21. Signature of Funeral Service I	icensee		22. Name and Addres				
_	707 # O		23a Part1. Enter the disease or	arally		· -			L1, Md. 207	745 Approximate
,8760,	Physician /Medical Examiner Cate pe executed physician and physician and the pniral transit	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):	Prentually	7			Onset and Death
Box 6	ath certifi attending p for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
P.0	that the de led by the a detached	Phy	9 Unknown					20 5:11		
	res tha signed be det	by	Part II. Other significant conditio	ns contributing to death i	out not resulting in the	underlying cause give	in in Part I.		pacco use contribute to	
Records,	w require been si should ?	Completed						1 □ Ye	es 2∭No 3□Pr	obably 4 Unknown
ec	e law has b	nple						24a. Was ar autops	y prior to d	topsy findings available completion of cause of
E E		S						perform		2 No
Vital	ıyaician: Th is certificate director, paç	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death	(Check only on	e)	
of	A S ID	2	1 ☐ Yes 2 🕅 No 27. Manner of Death	1 La Inpati			4 Nursing Hom		nce 6 Other (Spec	eify)
u	Per Ter	lo	1 X Natural 5 ☐ Pending		ay Year) 28b. Time Injury	Work	at ?? ∕es 2 □No	od. Describe no	w injury occurred	
Division	Attan or deat ector: by the	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of In	jury - At home, farm, stc. (Specify)			8f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitat or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Certifying Certifying	g Physician: To the best examiner: On the basis of and manner s	of examination and/or	ath occurred at the tim investigation, in my op	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To t withi To tl	Σ	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Month	n. Day. Year)
			AA	Pedick	710,50	00	044491		6/21/	·
	RA		30. Name and address of person v	vho completed cause of	death (Item 23a) (Type	e, Print)				0
_	110			rek. 750		TS RD.	CLINTO	N,ME	20735	
	Sta Registr		31. Date filed (Month, Day, Year)		rar's Signature	20				

								Health and I			e.
			1 - For State Registrar				tificate of			10g. No.200	5 22781
8	Physici	an	1. Decedent's Name (First, Middle, Last			-			2. Date of Dea Month	_	3. Time of Death
	/Medic	al	E VAN			144	LOR		JUNE	24 20	05 1550 PM
	Examir	er	4a. Facility Name (If not institution, give	te Hosfir	. (Suze	13	or Location of Death		4c. County of	
	Funeral		5. Social Securify Number 6. Se	x 7. Age		st birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birti	1.3.4	Birthplace (State or Foreign Country)
4	Director		Usual Residence of Decedent	M 2□F	88	Yrs.	Wildright Says	Tiodis Will.	APRIL S	1917	7.4
	yland 10w		10a. State 10b. County		10c. City,	Town or Lo	cation	1			10d. Inside City Limits
	r 28a-f ehow	ctor	MD KENT		C	HEST	ECTOUSA	J			1 ☐ Yes 2 No
	with the Maryland a or 28a-f ehow Lee notified at	Dire	10e. Street and Number	FOINT	E	2 . 4	10f. Zip Code	1620		10g. Citizen of Wha	
	ns 23	by Funeral Director	23660 FOX	12. Was Decedent E					pecify Yes or No-	14. Bace -	American Indian,
٥	or ital	Fur	1 Never Married 2 Marned	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo		Yes, specify Cui	Hispanic Origin? (S ban, Mexican, Puert Specify:	o Rican, etc.)		White, etc.
900	hours after tural', or Ita		3 Widowed 4 Divorced							Specify:	WHITE
<u>.</u>	within 72 ene then nate	Completed	(Specify only highest grad	e completed)		(Give i	ent's Usual Occu kind of work done OO NOT use retir	during most of wor	king	16b. Kind of Busir	ness/Industry
7 7	giene giene er the	Com	Elementary/Secondary (0-12)	College (1-4or 5-	+)	SAL	25 M	ANKER		STURACE	BATTERY CO
and	be file	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan		Maiden Surname)	
5	hould d Mer marke	٦	Rosser De	DONAL ME	1 1	100 Mailin	a Address /Ctree	VIRG	11319	EVANS	
2	nd 2 s lith an 27 is i		Patricia W. T	po, rivily r Dring & Section 1		7 %//	y Address (Siree	Rand Number or Au	rai Houte Numbe	r, City or Town, Sta	are, Zip Code) Z/620
ē.	of Head		20a. Method of Disposition	77000	20b. Pla	ce of Dispos	sition (Name of platory or other pla	ace)	Date	20c. Location · Cit	ty or Town, State
Ĕ	Peges ment of tant: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ S 1 ☐ Donation 5 ☐ Other (Specify,	temoval from State		SAPE	HEE CRI	MARIES	26/2003	CHESTE	2. 190.
Бащто	Depart Mport Mport Mny In		21. Signature of Funeral Service Licens	ee C		22	ARVIN	ress of Facility	475 けん	renova parece	21626
			23a. Part1. Filter the disease, or comp	ications that caused	the death.	2	05 62	EEN HER	213 64	7 (1185	Approximate
	Physician		Immediate Cause (Final	ne cause on each line	ie.	^	,		or respiratory and	.001,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	a conseque	ence of):	weens	YU.			1 Ping
	Examiner	1	Sequentially list conditions,	o. Due to (or as a		was offe					
	uted 1 ansit	Examiner	Sequentially list conditions, fary, leading to introduce at cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 03 0	a conseque	arico Otj.					
ĵ	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a	a conseque	ence of):					
-	cate be e physicien s the buria	dicai		d							
×	ding se as	Physiclan/Med	IF FEMALE:	3c. If yes, outcome o	of pregnan	cv					
ROX	death e atten ed for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal o	death 3 🗌	Ectopic pregnand Other (specify)	су 		23d. Date of Month	Day Year
Ç .	at tag	hys	9 Unknown	9□ Unknown							
S.	9 P 9	by	Part II. Other significant conditions co	ntributing to death bu	it not result	ting in the un	derlying cause g	iven in Part I.			ite to the cause of death? ☐ Probably 4 ☐Unknown
coras	noc noc	letec	Dolundent								•
He H	The law ate has b page 2 st	ompieted	De request eq	<u> </u>					24a. Was a autop perfor	sy prio med? dea	
	vicien: The lav certificate has rector, page 2	Be C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes th (Check only or		Yes 2 No
> . Io :	iding Physician: th. : After this certifice funeral director, f	ဥ	1 163 26 140	fospital: Inpatier		R/Outpatient	3□ DOA C	han		ence 6 Other ((Specify)
	ding F h. After funera	ation:	27. Mannar of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Yeer) 2	28b. Time of Injury		ork? □Yes 2 □No	28d. Describe h	ow injury occurred	
DIVISION	or or	ifica	3 Suicide 6 □ Could not be	28e. Place of Inju building, etc.	ıry - At hon	ne, farm, stre			28f. Location (S	treet and Number of	or Rural Route Number,
5	tel or rs afte el Dir	Certific	4 Homicide	building, etc.	. (Specify)				City or Tow	n, State)	
	Hospi 4 hour Funer Funer	ledical	(Uneck only 2 Medical Exami	sician: To the best o	examination	ledge, death on and/or inv	occurred at the t	ime, date and place	, and due to the c	ause(s) and manne	er as stated.
	To the Hospitel or Affi within 24 hours after of To the Funerel Direct completely filled in by	Med	29b. Signature and title of certifier	and marner stat	ted.			se number		29d. Date signed (A	
1	⊢ s ⊢ ŏ		> Mulher	25 K							
		7	30. Name and address of person who co	ompleted was of de	eath (Item 2	23a) (Type /	Print)	06630 SIES		-,,,,	, - ,
سنو	N. 10						on K) 51FS	CHES	1342 De	e, My
,	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 2 7 2	32. Rustra	ii s oignatu	At A	E. Walle				

			1 - For State Registrar	State of Maryland / Dep		Health and M	lental Hygie	•	22782
	Physici /Medio	al	Decedent's Name (First, Middle, Last) Barney Ellis Thoma Aa. Facility Name (If not institution, give st		4h City Tours	or Location of Death	2. Date of Death Month	Day Year 23 200	
	Examir Funeral Director	ier	Washington County 5. Social Security Number 6. Sex 220 76 1855	Hospital	Hagerst	OWN If Under 24 Hrs.	8. Date of Birth (Month, Day, Y Sept. 23,	Washingto Year) 9. Birt Co	
	ne Maryland 8a-f show pliffed at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Washington	10c. City, Town or L Hagerstow	m				10d. Inside City Limits X☐ Yes 2☐ No
	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 show deal Exartane must be inclified at	Funeral Director		Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 21740 Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	Un	g. Citizen of What Co ited State 14. Race - Ame Black, Whit	es erican Indian,
21215-0036	n 72 hours aft *neturel', or edical Exami	Completed by F	Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	1 Yes 2 No If Yes, Give Year or Dates: ation (Give tible)	1 Yes X No		ing 16	Specify: Wh:	
nd 212	be filed within ital Hygiene. Id other then event, the Mac	Be Comp	Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last)	College (1-4or 5+) None		,		None aiden Sumame)	
Maryland	and 2 should the salth and Ment and Ment of 12 is marked the treumatices	To	Barney Thomas 19a. Informant's Name/Relationship (Type Barbara Pasqual/Si		,		al Route Number, (City or Town, State, 2	Zip Code) ryland 21050
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at ODG.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Society) 21. Signature Fursid Service License	emoval from State 20b. Place of Disposemetery, cre Mount P1	osition (Name of ematory or other pla easant Cemeter 22. Name and Addre	June y 20	28, 005 Couch Fun	oc.Location-City or clora,Mary eral Home	Town, State
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not en	nter the mode of dyi		or respiratory arres		y Land 21901 Approximate Interval Between Onset and Death
1760,	ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions by cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
.O. Box 68	death certific e attending pl d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown		□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deli Month	ivery Day Year
Records, P	The law requires that the to have been signed by the bage 2 should be detached.	by	Part II. Other significant conditions cont	tributing to death but not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	o the cause of death?
Vital Rec	10	e Completed	25. Was case referred to edical			26 Place of Death	24a. Was an autopsy performe 1 Yes 24	ed? prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
of	ding Phye	ation: To B	eyaminer?	ospital: 1	of 28c. Inju.	ner: 4 ☐ Nursing Ho		ce 6 Other (Spec	cify)
Division	in the	i Certification:	3 Suicide 6 Could not be determined	28e. Place of fnjury - At home, farm, s building, etc. (Specify)			City or Town,		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ician: To the best of my knowledge, dealer: On the basis of examination and/or is and manner stated.	th occurred at the tinvestigation, in my o	opinion, death occur	ed at the time, date	ise(s) and manner as e and place, and due d. Date signed (Month	to the cause(s)
	\		30. Nameland address of person who con	The Hersows Thys mpleted cause of death (flem 23a) (Type 1489 DITOMAC	Print)	1) 09 4613057	359 (10HE 24	142
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 8 2005	Registrar's Signature	we .			- U	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 05 jertrude lanchuk /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Belair BelAu MO Harford Lonen OF 8. Date of Birth (Month, Day, Ye Dec. 10, If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday)), 1920 Ohio **Funeral** Months Hours 1 ☐ M 2 💢 F 84 Yrs. Director 217-12-9424 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Jes I am a someone to House the state of House the modified at or other treumette event, the Medical Example: must be notified at the contract of the state of th ty Yes 2 □ No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 630 Beards Hill Road 21001 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) To Be Com Hostess Resturaunt 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gertrude Perko Joseph Husvar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ralph Tanchuk (son) 630 Beards Hill Rd., Aberdeen, MD 21001 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cameleny, crematory or other place)
Harford Memorial Gardens 7/7/05 1 Burial 2 Cremation 3 Removal from State Aberdeen, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Tarring-Cargo Funeral Home, P Aberdeen, Maryland 21001-3399 rd1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line. Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Finat disease or condition resulting in death) · CEREBROVASCULAR d mos Examiner Due to (or es e consequence of): Examiner burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on or Attending Physician: The law requires that the death certificate be execut pue Box 68760by Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4X Unknown HYPERTENSION, ATRIAL FIBRILLATION, 24b. Were autopsy findings avaitable prior to completion of cause of deeth? 24 hours after death.
• Funeral Director: After this certificate has been sit letely filled in by tha funeral director, paga 2 should I 24a. Was an autopsy performed? Be Completed DIABETES MELLITUS, CORONARY ARTERY DISEASE, 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No HYPOTHYROIDISM
25. Was case referred to medical examiner? HYPERLIPIDEMIA 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. fnjury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 the 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number McClicerpen MD D45344 07/02 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 12 SURESH DHANTANI, MD, 6225-UNION ANE, HAVRE DE GRACE, MD 21078

1. Date filed (Month, Day, Year)

1. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) State JUL 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Shirley 5:30 4M Jean Taylor 3, 2005 4c. County of Death July /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner LUMBERLAND ALLEGANI SACRED TOSPITAL HEART 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country) March 15 1940 Maryland If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🖫 F 212-38-6502 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show 7 is marked other than "natural", or items 23a or 28e-f sho treumatic event, the Medical Examinar must be notified at Allegany Westernport txoxYes 2 □ No MD. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 421 Hammond St., Apt. 101 21562 United States Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married white 1 ☐ Yes 2XXXIo Specify: Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) if Heelth and Mental I Boyce Adam Henry Mary Laverne Hotchkiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Taylor/ son HC 84, Box 43, Arthur, West Virginia 26847 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 6 ¥XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/06/ permit. Page Dep rtment c Important: If any injury or Cumberland, Maryland Rest Lawn Mem. Garden * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ŏ Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? med? 2 X No 2□ No

The law requires that the death certificate be executed has o the Hospitel or Attending Physicien: Be 2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

Was s referred to medical examiner?

1			24a. Was a autops perfor
		26. Place of De	ath (Check only or
	_	Other	

10) 1 inpatient 2 ER/Outpatient 28b. Time of

3□ DOA	Other:	4 Nursing	Home	5 Residence	6 ☐Other (Specify)
	Injury a			Describe how inju	

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature

5 Pending investigation

6 ☐ Could not be

2**X**No

1 🗌 Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

2

this

After

Director:

death.

after

thin 24 hours a

Certification:

death (Item 23a) (Type, Print)

Hospital:

Charled MD 900 Seton 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature 2005

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 22785 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 20, 2005 **Physician AMY** THI 1:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2 🕱 F Yrs. 220-92-2168 87 Director 1918 Vietnam 1, Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Madical Examiner must be notified at Director 1 X Yes 2 No Montgomery Gaithersburg 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ 20877 or Items 23g 16 Autumn Hill Way United States death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after de la Hygiene.

Attypiene.

other than "natural", or Item □Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: à Asian Specify: 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wii Department of Health and Mental Hygiens Important: If item 27 is marked other tha any injury or other traumatic event, Item one. Tailor Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ngo Van Vo Ba Thi Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lan Mai Le (Daughter) 16 Autumn Hill Way Gaithersburg, Md. 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 23, `4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery Germantown, Md. 2005 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Colon Cancer Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit Causa (Disease or inju-that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) the : Ó The law requires that the à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death Check on one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 📉 No 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) Hospice 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) BR4216114 June 20, 2005 3 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Dr. #221 Rockville, Md. 20850 Dr. Chitra Rajagopal M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Terrill T. Veney 05-4383 AKG

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5	Physici	an	Decedent's Name (First, Middle, La	,		2. Date of De Month	eath Day Year	3. Time of Death			
	/Medi	cal	TERRILI			June 2		2:53 A M			
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	Farmalist		Holy Cross Hosp: 5. Social Security Number 6.	1tal Sex 7. Age (In yrs. last birthday)	Silver		Montgome	Ly thplace (State or Foreign			
	, Funeral Director		577-04-1407	1 ⊠ M 2□ F 31 Yrs.	Months Days	Hours Min. (Month, Da NOV . 20	ay, Year) Co	sh. DC			
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation			10d. Inside City Limits			
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	28a-	Funeral Director	10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,	10f. Zip Code		10g. Citizen of What Co	ountry?			
	3a or	O	12512 Veirs N	Mill Road, #302		0853	U.S.A.	,			
	death ms 2	nere	11. Marital Status			lispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.)	0- 14. Race - Ame	encan Indian,			
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ā		0	25. Was case referred to medical			26. Place of Death (Check only	2 No 1 X Yes	2 No			
>	Physicien: this certificinal director, I	To B	examiner? 1★2 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatien	nt 3 DOA Oth			cifv)			
o uois	anding Phath.		27. Manner of Death 1 Autural 5 Pending 2 Accident investigation		Wor		how injury occurred				
Division	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (City or To	(Street and Number or Ru wn, State)	ural Route Number,			
	To the Hospital or Attending Physical within 24 bours elected eath. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ★ Medical Exa	hysician: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.	h occurred at the tir evestigation, in my o	me, date and place, and due to the pinion, death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)			
)	To t To t	M	29b. Signature and title of certifier Zau Line Zau Line Mah Ah	29c. Licens OCM		June 29, 20					
			GASIUU	completed cause of death (Item 23a) (Type,	Print) 111 Pe	enn Street Balti	imore, Maryl	land 21201			
	Sta	ate	31. Date filed (Month, Day, Year)	005 32/Registrar's Signature	well !						

			For Si 1 - State Registrar	tate of Maryland	d / Depa		f Health a	nd Mental F	lygien	-		2278	7
	Physic	an	1. Decedent's Name (First, Middle, Last)					2. Date of Month	Death			3. Time of Dea	
	/Medi	cal		WILLIAMS				Jun			Year 5	7:16	Pm
	Exami	ner	4a. Facility Name (If not institution, give stree Shady Grove H				n, or Location of	Death	4	c. County of		ery	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye	ar If Under 2	4 Hrs. 8. Date of	Birth				oreian
	Director		220-32-5318 1 M Usual Residence of Decedent		Yrs.	Months Da	ys Hours	Min. Sept	Day Yea	,1932	. Mai	ace (State or Fo	
	arylar ehow	_	10a. State 10b. County		, Town or Lo						10	d. Inside City Li	
	he M. 28a-f cuitie	Director	Md Montgome	ery	SooTe	sville						1 X Yes 2 [
	with ta or the control	늅		na "226		10f. Zip Cod			10g. C	Citizen of W	hat Count	у?	
	death	Funerai	22600 Club Hollow	Was Decedent Ever in U.S	S. 13. 1			n? (Specify Yes or Puerto Rican, etc.)	No-		- America	ın Indian.	
9	after or Ite	골	1 ☐ Never Married 2 ☐ Married 1	Armed Forces? ☐ Yes 2 M No 1 Yes, Give				Puerto Rican, etc.)		Black	, White, e		
003	ural',	d by	3 EtWidowed 4 Divorced	fear or Dates:		1 □ Yes 22€1	чо Ѕреспу:			Specify:	Blac	ck	
15-	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-1 ehow ont, the Medical Exerting must be notified at	Completed	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. Dece (Give	dent's Usual Oc kind of work do	cupation ne during most (tired)	of working	16b.	Kind of Bus	iness/Indu	ıstry	
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Maryland 21215-0036	Menta Menta Marked	ToE	Bradshaw Palm				Cla		acmo				
Mar	d 2 sh th and th and 17 Is m traum		19a. Informant's Name/Relationship (Type, Florence Randoln	(Sister)	19b. Mailir 2.1.2	ng Address (Stre	eet and Number Woods	or Rural Route Nu.	nber, City	or Town, S rson	itate, Zip (Md	20342	:
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Hestih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any njury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licensee	+ 1 1 1 1		nowder	dress of Facility	cal Home	P.	A. 20	0850	Mā	
6			23a Part1. Enter the disease, or complication shock, or heart ailure. List only one care	ons that caused the death	. Do not ent	er the mode of o	vasning dying, such as c	oton St. ardiac or respirator	y arrest.	CKATI		Approximate Interval Betweei	
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	uted 1 ansit	Examiner	Sequentially list carditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	200 10 (01 03 0 00)	61100 017.						(
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٦,	res that igned to be deta	by PI	Part II. Other significant conditions contribu	uting to death but not resu	lting in the u	nderlying cause	given in Part I.	23e. D	d tobacco	use contrib	oute to the	cause of death	1?
ord	w require been sig should b	ted t	dementia					_ 1	☐ Yes	2 XNO 3	B □ Probal	bly 4 ∐Unkn	own
Records,	e law r has be ye 2 sh	Completed						24a. W	as an	24b. W	ere autops	sy findings avail	lable a of
E H	: The l	Co							rformed?	de	ath? Yes 2		
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ital:				f Death (Check on					(70)
of	Phys r this ral di	. To	1 163 23 140	Ba. Date of Injury	R/Outpatier 28b. Time of	t 3 DOA	Nurs	ing Home 5 R					
ion	nding F ath. :: After e funera	atior	1 Natural 5 Pending Accident investigation	(Month, Day Year)	Injury		njury at Vork? □ Yes 2 □ No		,0 11011 111	ary 00001161	.		
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	Be. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, offic	ce	28f. Locatio	n (Street a Town, Sta	and Number	or Rural I	Route Number,	
	ital or irs aft ral Di		<u> </u>										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2/ Medical Examiner:	n: To the best of my know On the basis of examinati and manner stated.	vledge, death on and/or in	occurred at the restigation, in m	time, date and y opinion, death	place, and due to t occurred at the tim	ne cause(ie, date ai	s) and mani nd place, ar	ner as stat nd due to t	ed. he cause(s)	
	within To th	Me	29b. Signature and title of certifier				ense number			ate signed			
)	3		2 TO AL	74.0		0	3702	4	14	we a	20.7	2005	
			30. Nam, and address of person who comple	7 M. D. eted cause of death (Item 7901 Medic.	23a) (Type,	Print)	1-1-	11- MA	7	100	2		
	St	ate.	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure 1	PR.	cac vil	ie ild.		-020			
	Regist		JUN 27 2005	32. Registrar's Signati	Span								

			_ For		aryland / Dep			-	•	•	
			1 - For State Registrar		Се	rtificate of	Death	Re	2005	22788	
	Physici	an	Decedent's Name (First, Midd					Date of Death Month	Day Yea		
	/Media	al	ROBERT 4a. Facility Name (If not institution	FRANKLIN	WILLIA		R or Location of Dea		23 , 200 4c. County of De		
	Examir	er	Holy Cross				r Sprin			tgomery	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday		If Under 24 Hrs	8. Date of Birth	1 9 5	Birthplace (State or Foreign Country)	
	Director		238-14-2650 Usual Residence of Decedent	XXM 2□F	8 2 Yrs.			Aug.22	,1922 No	o. Carolina	
	yland yland		10a. State 10b. County	,	10c. City, Town or L	ocation				10d. Inside City Limits	
	e Mar ta-fsh	ctor	MD Mon	tgomery	Rocky	ville				1. Yes 2 □ No	
	be filed within 72 hours after death with the Maryland stal Hygiene. id other than "natural", or items 23a or 28a-f show avant. I're Mudical Exartiner must be notified at	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
		eral	14309 Gain	2S AVE	Ever in IIS 12		20853	Spooily Voc or No	U.S.Z	A . nerican Indian,	
ഗ	after d or Item	by Funeral Director	1 Never Married 2 XMar	ried Armed Forces'	No No	Was Decedent of H		to Rican, etc.)	Black, Wi		
21215-0036	aral', c	d by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates 1965 – 1967 Specify: Specify: Black						Black		
5	"natu	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	nation during most of wo	rking 1	6b. Kind of Busines Bureau	ss/Industry Of	
212	yene.	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	gineer	2)			ng & Print	
g	be filed stal Hygi od othar avant, I	e e	17. Father's Name (First, Middle,			9111001	18. Mother's Na	me (First, Middle, M.	aiden Sumame)		
<u>ya</u>	2 should and Mer Is marke aumatic		Robert Franklin Williamson Sr Mamie Rush								
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14309 Gaines Ave Rockville, MD 20853								
	t Health		20a. Method of Disposition						c. Location - City		
Ë	Pages net of nry or o		20a. Method of Disposition 1 Removal from State 20b. Place of Disposition (Name of commetter), crematory or other place) MD Veterans Cem 20c. Location - City or Town, State								
Baltimore,	permit. Departr Imports any njt		21. A granture of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A.								
_	<u>705</u> g		246 N Washington St Rockville, MD 20850								
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hy rt failure. List only one cause on each line. Immediate Cause (Final Onset and Death								
			Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of):								
		Examiner	Sequentially list conditions		Cerebrovascular Accident 4 days						
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Myocardial Infarction Due to (or as a consequence of):								
	be executed sician and burial-transit	xan									
760,	nte be e nysiciar ne buri	cal	d								
. 68			IF FEMALE:								
Вох	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)						23d. Date of d Month	23d. Date of delivery Month Day Year	
O. B	t the de by the a tached t	nyslo									
o.	The law requires that the ate has been signed by the bage 2 should be detache	e Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?							to the cause of death?	
Records,	w require been sig should t		Hypertension 1 Yes 2/2 No 3 Probably 4 Unk							Probably 4 Unknown	
Šec	has b		autops					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
	n: Th ficate or, pag		performed 1 Yes 2						2 death? No 1 ☐ Yes 2 ☐ No		
Division of Vital	Physician: The law this certificate has t ral director, page 2 s	0 0	25. Was case referred to medical examiner? 1 Yes 2 No								
ا ا	or Attanding Pi fter death. Diractor: After th in by the funera	cation; T	27. Manner of Death 11 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred 18d. Describe how injury occurred								
200			2 Accident investigation M 1 Yes 2 No								
\leq		Certificati	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)						et and Number or I State)	Rural Route Number,	
	To tha Hospital or within 24 hours after To tha Funaral Dir completely filled in	edical	29a. Certifier & Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To tha Howithin 24 To tha Fu		(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.						ue to the cause(s)		
	To To corr	Σ	1/-1 2 60 0 0 110							te signed (Month, Day, Year)	
	φ		30. Name and address of person				0826		June 23	, 2005	
			Kshama Garg,			*	er Spri	ng, MD 2	0906		
	» Sta		31. Date filed (Month, Day, Year, JUN 2	7 2005 32. Abgisti	rar's Signature	marker					
	Registr	ar	JUN A	L COOL	150 10 19	A COLUMN					

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I		Mental H		005	22789			
	Physici		Decedent's Name (First, Middle, Last Robert Lyle Werth)				2. Date of D Month June	eath Da		3. Time of Death 8:30 a M			
}	/Medic Examir		4a. Facility Name (If not institution, give Holy Cross Hospital		· ·		or Location of Dea			. County of Death				
	Funeral Director		579-03-2129	x 7. Ag ☑M 2□F	e (In yrs. last birthday) 90 Yrs.									
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo	orqe's	10c. City, Town or L	ocation					10d. Inside City Limits 1 ☐ Yes 2X No			
	with the	I Director	10e. Street and Number 10020 Riggs Road		·	10f. Zip Code	13		10g. Ci	tizen of What Cou	ntry?			
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or itame 23a or 28a-f show amy integrate other treumatic event, the Medical Examinar must be natified at any integrate other treumatic event, the Medical Examinar must be natified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of I If Yes, specify Cub	Hispanic Origin? Jan, Mexican, Pue	(Specify Yes or Norto Rican, etc.)	10-	14. Race - Ameri Black, White, Specify: White	etc.			
21215-0036	ed within 72 hagiene. er then "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu e kind of work done DO NOT use retire ficer	during most of w	orking		ings & Loar	•			
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the M	To Be (17. Father's Name (First, Middle, Last) Robert William Werth	1				ame (First, Midd Taunton Sc		,				
, Mar	and 2 sho alth and 1 27 is ma		19a. Informant's Name/Relationship (T) Robert Holmes Werth/			ng Address <i>(Str</i> ee) East-West H			-					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injustrate other tre once.		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disp	osition (Name of matory or other pla	ice)	June 30, 2005	20c. L	ocation - City or To	own, State			
Balti	Departm Departm Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD											
	Physician		23a. Part1. Enter the disease, or comushock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lin		ter the mode of dyi	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death			
8760,	Medical Examiner ohysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coro Due to (or as	a consequence of). a consequence of):	ari	test enga	dise	as a	e.	yrs.			
O. Box 6	The law requires thet the death certificate be executed ate has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			23d. Date of delive Month	ery Day Year			
rds, P	w requires thet been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	inderlying cause gr	ven in Part I.		tobacco Yes 2		he cause of death?			
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Vital	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott		eath (Check only						
of	Phy this af d	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		of 28c. Inju	4 Indising	Home 5 Re 28d. Describe		6 □Other (Specifing occurred	(ý)			
27. Manner of Death Addural Statural S							28f. Location City or T	(Street ar own, State	nd Number or Rura a)	al Route Number,				
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example (Check only one)	sician: To the best iner: On the basis o and manner st	of my knowledge, deal f examination and/or in ated.	th occurred at the tinvestigation, in my	me, date and place opinion, death occ	ce, and due to the	e cause(s e, date an) and manner as s d place, and due to	stated. the cause(s)			
	To t To t	Σ	29b Signature and title of certifier	/		29c. Licen				te signed (Month,				
{	140		30. Name and address of person who c	ompleted cause of d		Print)	987	21.00		0/24/05	. 1			
	Sta	at <u>e</u>	AtmED NAVA 31. Date filed (Month, Day, Year) JUN 2 7 200		BOX 838	319, GA1	THERSE	sukg, n	עע ק	20883				
	Regist		JUN 27 200	13 Stewar	, St. F.	MELL								

Registrar

State

31. Date filed (Month, Day, Year)

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2005

BALLES

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 20, 2005 ear Mazie Washington 2045 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Country) | Sept. 28,1912Maryland 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🖫 F Yrs. 579-18-8601 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturef", or items 23a or 28a-f show the Medical Examinational be politive at 1 ☐ Yes 2 ☑ No Director Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1830 Stinnett Road 20639 USA Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
nent of Health and Mental Hygiene.
ant: if tiem 27 is marked other than "neturel", or tiems 23.
ury or other treumatic event, in a Mencial Examina mun Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Math Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freeland George Edith Bowen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5330 East Capitol St.NE Washington, D.C. 20019 Tyrone J. Mason/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Plum Pt. UMC Cem. 6/27/05 Huntingtown, MD *4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home Bladys 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL VASCULAR ACCIDENT Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, VALUE. DISEASE 1 X Yes 2 No 3 Probably 4 Unknown LUNG 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? OBSTRUCTIVE certificate 1 Tes 2 No 2 No 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1.X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40370 6/21/05 M.U. 30. Name Ind address of person who completed cause of death (Item 23a) (Type, Print) 10 Peter Wisniewski, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registres Signature State JUN 2 2 2005 > Registrar

DHMH 17 Rev 1/2001

		•	For State	State of Marylar	nd / Department of H Certificate of		0	DOF 1	22702	
			Registrar 1. Decedent's Name (First, Middle,	Last)	Continuate on		Reg. Mo	2000	3. Time of Death	
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	/Medio Examin		4a Facility Name (If not institution,			Location of Death	40	County of Death		
			teningula Regi	ona Medical	Center Salis	bury	6	VICANU (Ó	
	Funeral		5. Social Security Number	5. Sex 7. Age (In yrs. 1 M 2 F	Months Dave	Hours Min. (Mc	e of Birth onth, Day, Year)	Coun	ace (State or Foreign try)	
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	yland		10a. State 10b. County	10c. Ci	ity, Town or Location			10d. Inside City Limi		
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	or 26	Dire	10e. Street and Number		10f. Zip Code	1	10g. Ci	tizen of What Coun	try?	
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	iter de	Fun	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Decedent Ever in U Armed Forces? 1 New 2 □ No	If Yes, specify Cuba	lispanic Origin? (Specify Ye an, Mexican, Puerto Rican,	etc.)	14. Race - Americ Black, White,		
036	al', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 Syes 2 □ No Wyes, Give Year or Dates: ARW	1 Yes 2 70 No	Specify:		Specify: BL	ACK	
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121	within ine. ihan *	d E	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	d)				
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an	ld be ental ked o	To Be	EUGENE			ESSIE		GATE	en	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene and Health and Mental Hygiene from them 23a or 23a-1 show item 27 ia marked other than "natural", or items 23a or 23a-1 show other traumatic event. The Medical Examiner must be notified at	-	19a. Informant's Name/Relationshi		19b. Mailing Address (Street					
-	1 and 2 Health a iem 27 la		CARRIE M. WA	MSON ~ WIFE	403 SOUTH KA	MWOOD DRIVE.	SALISB	URY MD.	21801	
ore	of He		20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other place	Date		ocation - City or To		
Ë	Pages ment of I tant: If it	6	4 □ Donation 5 □ Other (Spe		PRING HILL CEM	6/30/05		BRON M	D	
Baltimore	permit. Pages Department of Important: If i any injury or o	1	21. Signatur - Arm, ral Service Li	censee	22. Name and Addre	ss of Facility BENI	-00-0	nITH FI	H	
	401 8 4	\vdash	23a. Part1. Enter the disease, or c	complications that caused the dea	th. Do not enter the mode of duin	SABELLA ST		BURY MI	Approximate	
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Division	or Atl	Certification:	3 Suicide 6 Could no 4 Homicide determin		nome, farm, street, factory, office ify)	28f. Loc Cit	cation (Street all y or Town, State	nd Number or Rura. e)	Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying	Physician: To the best of my kn	owledge, death occurred at the time	no, date and place, and due	a to the cause/s	and manner or et	ated	
	e Hos 124 h e Fur letely	Medical	(Check only 2 Medical E	xaminer: On the basis of examination and manner stated.	ation and/or investigation, in my o	ppinion, death occurred at the	ne time, date an	d place, and due to	the cause(s)	
	To th Withir To th comp	Me	29b. Signature and title of certifier	mo	29c. Licens	e number	29d. Da	ate signed (Month, I	Day, Year)	
	to				D	54127	Transmitted and the second	6/23	105	
	2,4		30. Name and address of person w	no completed cause of death (Ite	m 23a) (Type, Print)	1 1			· •	
	1.1		31. Date filed (Month, Day, Year)	nb 100 Yowe	r Street 2	allsburg N	10	21804		
	Sta Regist		JUN 2	4 2005 32. Regigrar's Sign	om 23a) (Type, Print) Street Separation	U				

James Williams Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04153 State of Maryland / Department of Health and Mental Hygiene NJM State
Registrar Amend #5.Per.Fam.PGC 7-7-05cr Certificate of Death Reg. No. 0 5 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician James Williams, Jr. 2045 June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 800 East Tantallon Drive Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12€ M 2 ☐ F Yrs. Director 59 July 26, 1945 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland | Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Menta! Hygiene. ant: If item 27 Is marked other then "natural", or Itema 23e or 2 20744 901 Newmont Street United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Forces,

1 Syes 2 No
If Yes, Give 1963 to
Year or Dates: 1966 1 Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Entrepreneur Private of Health and Mental Hygie fitam 27 is marked other i r other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be James Williams Laura Mae Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Newmont Street; Ft. washington, MD. Evon Williams/Spouse 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or of once. Maryland Veteran Cem. June 27,2005 Cheltenham, MD. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Forestville, MD. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Junshot Wounds disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□ Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, sign 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 🗆 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1X Yes 2 No Other: 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Scene After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; Injury 1 Natural 5 Pending 8.30 P 1 ☐ Yes 2 🗖 No Sub lect investigation 6 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Jown, State) SOO BLK E. Tantal (c) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

Hospital or Attanding Physician: Diractor: within 24 hours after To the Funeral Dire

Medicai State

29c. License number

1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner all stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

OCME June, 18, 2005

Ht

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 2 8 2005

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

wel

Registrar

		1 - For State of Mary		artment of H			ene	22791.
Physic		1. Decedent's Name (First, Middle, Last) Robert Phillip Willi:	3			2. Date of Death June		3. Time of Death 10:45P M
/Medi Examir		4a. Facility Name (If not institution, give street and number) 4695 Priestland Rd.		4b. City, Town, or Unior	Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 217-32-6474 6. Sex 1 M 2 □ F 68	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 28		nplace (State or Foreign unity) yland
aryland ahow	'n		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕍 No
ith the M or 28a-f or celiffs	Funeral Director	10e. Street and Number		10f. Zip Code	nion Brid		g. Citizen of What Co	untry?
death w	nerai	4695 Priestland Rd. 11. Marital Status 12. Was Decedent Ever	in U.S. 13.)	Was Decedent of His f Yes, specify Cubar	21791 spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
partitions, intal yielling 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow any niqury or other traumatic event, the Medical Examinar must be routiled at ADDGs.	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give Year or Dates:		if Yes, specify Cubar	Specify:	Rican, etc.)	Specify: B1	ack
thin 72 h e. an "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of worki)	ing 1	6b. Kind of Business/	•
filed wi Hygien other th		10 17. Father's Name (First, Middle, Last)	main	itenance o	18. Mother's Name	(First, Middle, M	county go	v't.
should be not Mental in marked our umatic eve	To Be	Herbert Luther Willis					a Hammond	
and 2 sh and 2 sh salth and n 27 fs m		19a. Informant's Name/Relationship (Type, Print) Regina M. Torrence/ companior		ng Address <i>(Str</i> eet a 5 Priestla			City or Town, State, 2 Bridge, MD	
mit, Pages 1 a pertment of He pertant: if item y injury or othe		1 Burial 2 Cremation 3 Bemoval from State		sition (Name of matory or other place	9)		Sykesville	
permit. Dep. rtm Impc.rts any inju		21. Signature of Funeral Service Licensee		. Name and Addres			neral Home dge, MD 21	
Physician		23a. Part1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not ent		g, such as cardiac c		and the same of th	Approximate Interval Between Onset and Death
/Medical Examiner	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nsequence of):		Lung	CIAN	RI	5425
icate be executed physician and sthe burial-transit	dicai	resulting in death) Last Due to (or as a co	nsequence of);					
The COLUS, T.O. DOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of principle in the past 12 months? 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	it.	-	23d. Date of deli Month	very Day Year
w requires that been signed the should be deta	by	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	on in Part I.	23e. Did tob	acco use contribute to	the cause of death?
VICAL DECC Nician: The law re certificate has be rector, page 2 sh	Completed					24a. Was an autopsy perform 1 Yes 2	prior to c	topsy findings available completion of cause of
VICAL Alclan: 7 s certifical director, p	o Be	25. Was case referred to medical axaminer? Hospital: 1 Inpatient	2 ☐ ER/Outpatien	nt 3 DOA Othe	26. Place of Death Pr. 4 ☐ Nursing Hor		nce 6 Other (Spec	ufu)
off of this this tuneral di	ation: T	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Ye	ar) 28b. Time of Injury	f 28c. Injury Work	at ?	28d. Describe hor		,,
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertificat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, str pecify)		/es 2 □No	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Hospital 24 hours : 9 Funeral etely filled	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my and manner stated.	y knowledge, death mination and/or in-	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of Settifier		11	number d330		d. Date signed (Month	, Day, Year)
Wa		30. Name and address of perso we completed cause of death	(Item 23a) (Type,	Print)	VMor	EMOO	E MI	smol
St	ate	31. Date filed (Month, Day, Year) 32. Resistrar's S	Signature	1			, , ,	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) 339 **Physician** HRISTINE /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner SALISBURY
Vaar | If Under 24 Hrs. Willomico 10 nA Medical Centre eninsula 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F MD-365 215-14 Director Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □ Yes 2 No SOMERSET Be Completed by Funeral Director HANCE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 2182 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Maritat Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 50FU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DALISBURY MD 2

20c. Location City or Town, State BEVER 225 DAUGHTEA 25-6-6-7

20b. Place of Disposition (Name of cemetery, crematory or other place, Baltimore, 20a. Method of Disposition 128urial 2 Cremation 3 Removal from State 05 4 ☐ Donation 5 ☐ Other (Specify) ES 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NIE permit. EN SABELLA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition resulting in death) **Physician** YOCATOLA /Medical Due to (or as a consequence of) **Examiner** orunan Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit IMONAR physicien and Due to (or as a consequence of Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. the detached 9 Unknown 9 Unknown Part tt. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 Probably 4 Hinknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate has 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 1 Impatient Ţ Pis 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 1 ☑ Naturat 28a. Date of Injury (Month, Day Year) 28h. Time of Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Simpature and title of continer D 33796 who completed cause of death (Item 23a) (Type, Print) E Carroll Street Salisbung Walker 100 L 0 7 2005 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

				partment of Health and Mertificate of Death		ene .2005	22796						
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Rev. Joseph E. Woods, O.	S.F.S.	2. Date of Death Month July	Day 2005	3. Time of Death 0300 A M						
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
			Annecy Hall	Childs If Under 1 Year If Under 24 Hrs.		Cecil							
	Funeral Director		5. Social Security Number 222-60-0028 6. Sex 1 M M 2 F 7. Age (In yrs. last birthd) 88 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Cou	place (State or Foreign Intry) Laware						
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	1			10d. Inside City Limits						
	Aanyla f show	ō	Maryland Cecil Childs				1 ☐ Yes 2 🎇 No						
	28a-	rect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?						
	h with	al D	1120 Blue Ball Road	21916		United Sta	ates						
	ams ams	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White							
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event. The Modical Examinating modified at once.	Completed by Funeral Director	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify:							
21215-0036	2 hou	ted t	15. Decedent's Education 16a. De	cedent's Usual Occupation	. 16	Bb. Kind of Business/I	ite						
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ary	shoul and Mark s mark	F		ailing Address (Street and Number or Rura		City or Town, State, Zi	p Code)						
Σ	is 1 and 2 of Health a itam 27 Is othar trau			Kentmere Parkway,	Wilmingt	on, Delawa	re 19806						
ore	ges 1 t of He If itan or oth		1 X Burial 2 □ Cremation 3 □ Removal from State	sposition (Name of rematory or other place) July		Oc. Location - City or T	own, State						
Baltimore,	it. Par rtmen rtant: njury			e Cemetery 200		Childs, Man	cyland						
Bal	permi Depa Impo any ir		" Doned & Hury	22. Name and Address of Facility. Hicks Home for Fune 103 W. Stockton Str	eet, Elk	ton, Maryl							
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter the mode of dying, such as cardiac of	or respiratory arres	ι,	Approximate Interval Between Onset and Death						
	Physician /Medical		disease or condition esulting in death) a										
	Examiner		Sequentially list conditions b. Plasma Cyl	000			15 years						
αi	Si tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury										
7	death certificate be executed e attending physician and od for use as the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
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0	the de	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 ☐ Other (specify)									
Q.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?						
ords	en sig	led b	type 2 diabetes rellitus		1 🗆 Yes	2 No 3 Pro	bably 4 🗆 Unknown						
Vital Records,	8 C	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of						
al B	The ate					ZNo 1 □ Yes	2 No						
	Phyaician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor	me 5 esiden		(4.1)						
J of	ding Phya n. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		197						
Sior	Attending ir death. actor: After by the fune	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No									
Division	l or Attendatter deatt Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,						
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place,	and due to the cau	se(s) and manner as :	stated.						
	ha Ho in 24 t ha Fu pletely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	investigation, in my opinion, death occurr	ed at the time, date	e and place, and due t	to the cause(s)						
	with To 1	Σ	29b. Signature and the of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)						
7			Com Com M	(3-000)	~~ J	My 5,20	os						
_	10		30. Name and address of person who completed cause of death (Item 23a) (Tyr) Christine E. K. Horah, D.D. 412	Suburban Plaza	· Vew	ork Delo	ware 1971						
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 1 2005 32. Registrar's Signature	les .	•	•							
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			ricase	State of Ma	ndan	d / Don	uelib admo	nt of L	colth a	nd Ma	ntal Hv	gione	egible.		
			1 - For State Registrar	State of Ma	arytani	u / Depa Ce	arume rtifica	te of E	eaim ai Death	nu ivie	niai ny	Reg. No.	105	2279	7
			Decedent's Name (First, Middle, Last	0						2	. Date of De.		Year	3, Time of Dea	th
	Physici /Medio		Clarence	Widde	W.C	S					Ole	مأثي	05	1615	М
	Examin		4a. Facility Name (If not institution, give			11:11	4b. Cit	, Town, or	Location of	Death		4c. Co	unty of Deat	f	
			Harrison Senior L 5. Social Security Number 6. Se	Y 7 AGE	MOUS I	ast birthday)	If Und	NOU.	If Under 2	4 Hrs. R	. Date of Birt	in U	Or CO		reian
	Funeral Director		214-09-5012	M 2□F	90	Yrs.	Month	Days	Hours	Min. J	(Month, Da [uly 7	, 1914	Ma	hplace (State or Fo untry) ry Land	o.g.,
	D .		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside City Li	mite
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	r 28a-	Director	10e. Street and Number				10f. Z	ip Code				10g. Citizer	n of What Co	untry?	
	filed within 72 hours after death with the Maryland Hygiene, then "naturely, or itema 23a or 28a-f ahow ent, tra Medical Examinar must be notified at		6125 Snow Hill R	load				2186	3			US	SA		
	er des	unei	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Dec	edent of His ecify Cubar	spanic Origi n, Mexican,	in? (Specif Puerto Ric	fy Yes or No can, etc.)	- 14.	Race - Ame Black, White		
39	irs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1. ∑Yes 2 □ N If Yes, Give Year or Dates:	WW I	I	1 🗆 Yes	2K No	Specify:			Sp	ecify:	white	
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an	Mental Mental arked o	To Be	Roy F. Widdows								e Ride				
E .	and and lis m		19a. Informant's Name/Relationship (T)	•							Route Numbe				
	1 and Health 16m 27		William Widdows - 20a. Method of Disposition	· son	20h Pi	lace of Diene	eition /A	ama of	7	, Sno			ion - City or	21863	
nor	Pages nent of h nnt: If Ite iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,		CE	emetery, crei	matory of	other place		/30/0				, Marylan	d
Baltimore,	그 문원들 .		21. Signature of Foreral Service Licens						s of Facility		NICH I				_
Ö	Depa Impo any i		* scott n	Mun	nel	4	15 E	. Wil	son B					yland 217	40
ř.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death	n. Do not ent	er the m	ode of dying	, such as c	ardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Deati	
_	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEP.											
	Examiner			Due to (or as a			RTE	V 0	ISEAS	=					
25		ner	Sequentially list conditions, if any, leading to immediate cause. Enier united lying Cause (Disease or injury	Due to (or as a			-101	- / (0	.o criq						
	and and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
760,	ate be executed nysician and he burial-transit	cal E		Due to (or as a	a consequ	ience or);									
	leath certificate be attending physical for use as the b			d											
XO	anding nuse	M/us	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Tectopic	pregnancy				23d	. Date of deli	,	
Division of Vital Records, P.O. Box	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown			Other (Month	Day Year	
<u>a</u>	that the de led by the a detached i	by Physician/Med	Part II. Dther significant conditions co	ontributing to death br	ut not resu	ulting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death	?
rds,	quires tha n signed utd be del										101	res 2 🗗 1	√0 3 □ Pr	obably 4 Unkn	own
OO	aw require is been sig 2 should b	piete									24a. Was	an 2	4b. Were au	topsy findings avail	able
Ä	The lav	Completed										med?	death?	2 DNO	Oi
Vita V	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	-400		Check only o				
5	Phys r this sral dii	To To	1 ☐ Yes 2 ☐ No 27. Manney of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatier 28b. Time o		28c. Injury Work	4 Mur		5 Resid			cify)	
on .	nding ath. r: Afte e func	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury	М		? ′es 2 🗆 N	0					
N S	or Atterde terde irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At ho	me, farm, sti	eet, fact	ry, office		281	Location (S City or Tox	Street and N vn, State)	lumber or Ru	iral Route Number,	
Ω	Hospital or Attending Physician: The law requires that the death certificat 24 hours after death. Funeral Director: After this certificate has been signed by the attending phy filled in by the funeral director. page 2 should be detached for use as the		29a. Certifier 1 Certifying Phy	veicies: To the best	of my know	wledge deat	h 0000000	d at the tim	o dote and	place and	d due to the	201127(2) 25	d ====================================	atota d	
	of the Hospital or Attending Physician; within 24 hours atter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only one)	ysician: To the best of iner: On the basis of and manner sta	examinat	ion and/or in	vestigati	on, in my op	inion, death	occurred	at the time,	date and pla	ace, and due	to the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	d N				9c. License						h, Day, Year)	
•			Jalye					1006	2177	2-		6	27/3	1005	
1-6	+1		30. Name and address of person who c			23a) (Type, 4 MAR		5- 2	กเภณ	ike f	TY M	10 2	1851		
	Sta	ite	31. Date filed (Month, Day, Year) JUN 28 20			ture			J -0 1110		11/10	10 6	. 001		
	Registr	rar	JUN 2 8 20	105	- 1	4. A	a. M.	,							

ORIGINAL

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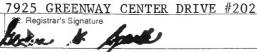
State Registrar

JUN 2 7 2005

DIVYA VERMA, MD

31. Date filed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



GREENBELT, MD 20720

Physician /Medical Examiner Funeral Director	1 - State Registrar 1. Decedent's Name (First, Middle		ertificate of I	veatn		Reg. No. []	. 7711
/Medical Examiner Funeral	1. Decedent's Name (First, Middle					3 6 0 0	
Examiner Funeral		Mauricio Zepeda-Rodri	i au a a		2. Date of Dea	Day Y	3. Time of Dea
Funeral	4a. Facility Name (If not institution			r Location of Death	June	23, 2005 4c. County of	9:40 P
	8300 Oxon Hill		Fort Was				
	5. Social Security Number	6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year		8. Date of Birt	th PLINCE	George's Birthplace (State or Fo.
Director	None	XX ^M 2□ F 18 Yrs	Months Days	Hours Min.	8. Date of Birt Sept. 22	2,1986 M	Country)
P .	Usual Residence of Decedent						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "neturel; or items 23a or 28e-f ehow any figury or other traumatic event. Its Modical Examinar must be nuitled at once. To Be Completed by Funeral Director	10a. State 10b. County	, , , , , , , , , , , , , , , , , , , ,					10d. Inside City L
after death with the Ma or Items 23a or 28e-1 officer over the notifier Funeral Directo	Maryland Prince	e George's Fort Wa	ashington				1 □ Yes 2]
with the bendered	10e. Street and Number	D 1	10f. Zip Code			10g. Citizen of Wha	it Country?
s 23	8809 Oxon Hill		207			Mexico	
Item Item	11. Marital Status 1 Never Married 2 Mar	Amed Forces?	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
el', or	3 ☐ Widowed 4 ☐ Divorced	Specify:]	Hispanic				
eture rale		Year or Dates: 16a. De	ecedent's Usual Occupa	ation		16b. Kind of Busin	ess/Industry
ygiene. her then "netur t, tre Medical t	(Specify only higher Elementary/Secondary (0-12)	st grade completed) (G	ive kind of work done o e. DO NOT use retired	durina most of worki	ng		
or the	8th		orer			Landsca	ping
d other ray	17. Father's Name (First, Middle,	Last)		18. Mother's Name	(First, Middle,	Maiden Sumame)	
arked atic •	Heliodoro Zepe	da-Colin		Maricela	Rodri	iguez Sor	iano
S me	19a. Informant's Name/Relations		ailing Address (Street a				
n 27	Patricio Zepeda-	-Colin/Uncle 8809	9 Oxon Hill	Rd. Ft.	Washing	gton,MD.20	0744
ig di	20a. Method of Disposition 1 □ Burial 2 □ Cremation	comoton:	sposition (Name of crematory or other place	اه	ate	20c. Location - Cit	y or Town, State
ury o	'4 □ Donation 5 □ Other (S	Specify) Panteon	Municipal	Monpani /	/1/05	Quereta	aro, Mexico
Importe any Inju	21. Signature of Funeral Service	License	22. Name and Addres	ss of FacilityGeo.	P. Kal		
트등리	Lugar & K	also 1)	160 Oxon H				
	23a. Part 1. Enter the disease of shock, or heart failure. List	complications that caused the death. Do not only one cause on each line.	enter the mode of dyin	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Betwee
sician :	Immediate Cause (Final disease or condition	Hanging					Onset and Dea
edical	resulting in death)	Due to (or as a consequence of):					1
niner	Sequentially list conditions	b. ————————————————————————————————————					
i ii	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
in and ial-transit	that initiated events resulting in death) Last	c					
ourial E		Due to (or as a consequence of):					
the the colored		d					
Me as	IF FEMALE:	220 16 120 214 227 24 227 24					
ed by the attending physician detached for use as the buria	23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy			23d. Date of Month	delivery Day Year
the character the d	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			, was	July 1001
Ph detac	Part II. Other significant condition	ons contributing to death but not resulting in th	e underlying cause give	an in Part I	23e Did to	hacco use contribu	te to the cause of death
p g			o underlying oddoo give	or in a die i.			Probably 4 Dunkn
should should					-		
200					24a. Was a autop	sy prior	e autopsy findings avai to completion of cause
certificate harector, page					perfor		n? Yes 2∐ No
is cartific director, To Be (25. Was case referred to medica examiner?		04	26. Place of Death			
T T	1 X Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpa		4 Unursing Hor			Specify)at scer
After th funeral tion; T	1 Natural 5 Pendin	The state of the s	y Work	/ at 2 (? You 2157his 5		ow injury occurred	1
the fu	2 ☐ Accident investing 3 ☐ Suicide 6 ☐ Could	round becomes hours	7.43			anged Self	
el Director: After i led in by the funera Certification;	4 Homicide determ	building, etc. (Specify)	street, ractory, onice		City or Tow	m, State) Reco	r Rural Route Number,
	29a. Certifier 1 Certifyir	ng Physician: To the best of my knowledge, do	agth conversed at the time	and data and along		F4. U.M. Shins	Transfer D
he Fune pletely fil edical	(Check only 2 Medical one)	Examiner: On the basis of examination and/o	r investigation, in my op	ie, date and place, a pinion, death occurre	and due to the dead at the time, o	ause(s) and manne date and place, and	due to the cause(s)
o the	29b. Signature and title of pertifie		29c. License	number	- 2	29d. Date signed (M	Ionth, Dav. Year)
- 0		1 1/10	OCI	Æ		June 24.	
(2)	30 Name and address of said	who complete a true of death (Harmon) or	no Brint)				
10	30. Name and address of person Mary G. Rin	who complete dause of death (Item 23a) (Type ple MD	111 Per	n Street	Baltin	more, Mar	yland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 12:28 pM 570N 2005 FFREI JUL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE NIA AGNES HEALTH ARE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Months 100M 2□ F 212-96-444 MAR LAND Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No TIMORE MARVLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code CIRCLE DRIVE SA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 🗖 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) DISABLED 2 HIGRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JOHN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IZABETH ALSTON CATONSVILLE MD. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State ZION CEMETERY 07 -ANS DOWNE * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN 3945 N. FULTON AVE. LIR FUNERAL HOME 21. Signature of Funeral Service Licensee BALTO, MD 21217 wine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRSA -PNEUMONIA 4 MONTHS disease or condition resulting in death) Due to (or as a consequence of) SSOCIATED ENTILATION Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

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To the Funerel Director: After thi
completely filled in by the funeral

within 24 hours a To the Funerel C

The law requires that the death certificate be executed

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Division of Vital

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Department o Importent: If any injury or once.

filed within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore.

the Medical Examinational be notified at

Director

Funeral

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Completed

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10a State

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NCEPHALOPA

3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2 **□**1√0 1 ☐ Yes

25. Was case referred to medical examiner?
1 Yes 2 No

26. Place of Death (Check only one) Hospital: Other: 1 Minpatient 2 □ FB/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending 1 Natural investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

-AKSHMI

29a. Certifier

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

P19512

JULY - 11 - 2005

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAKTHIVELNATHAN, 900, SOUTH CATONS AVE, BALTIMORE, MD - 21229

State Registrar 31. Date filed (Month, Day, Year) 3 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Richard Douglas Archambeault 07 07 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General 01ney Montgomery If Under 1 Year 8. Date of Birth (Month, Pay, Year) 02-0/-1956 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 152M 2□F 49 212-68-6055 Washington DC Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 17 is marked other then "neturel" or items 23a or 28e-f show traumatic event, the Madical Examinating must be notified at MD 1 ☐ Yes 2√No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1350 Elm Grove Circle 20905 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Postal Worker Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be Mental Laurier Archambeault Theresa Dunohoe Juges 1 and 2 s. Juges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keri Archambeault (wife) 1350 Elm Grove Circle Silver Spring MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation ² 5 □ Other (Specify) Chesapeake Crematory 07-09-2005 Beltsville MD Cremation Service 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer with CNI Metastatic Disease 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical use as the attending IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No õ Month Year Day 4 Pregnant at time of death 5 Other (specify) à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 1 Tyes 2√XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 덫Inpatient Other: ပ 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3EXNo this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; After or Attending 1x Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deati To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mar , no D23630 07-07-2005 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 Frederick Ave #213 Gaithersburg MD 20870 Frank J. Mayo

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month)

L 1 3 2005

P.O. |

Division of Vital Records,

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. NO 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Hnderson 04 300 /Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hostritol Baltimore General gruland tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-16-58 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In rs. last birthday) **Funeral** Months **™** M 2□ F 46 Yrs. 219-74-9469 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits ih and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 501 Franklin St. USA Funeral W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married SpecifBlack 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 8th Driver Car Dealer permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tem 27 is marked othe any injury or othar traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Naomi Plummer Louis A. Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosemary Anderson 1603 E. Eager St.Apt 102 Balto.MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 7-18-05 Dundalk, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wesley Chavis Jr. FH 21. Signature of Funeral Sen ice License 2007 Eastern Ave. Balto. MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician en nram /Medical Due to (or as a consequence of) Examiner unaemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed quired Due to (or as a consequence of): Box 68760, Physician/Medical Mamay attending p IF FEMALE: 23c. tf yes, outcome of pregnancy 1□Live birth 2 □ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 No 1 Yes 22 NO director, Be 25. Was case referred to medical examiner? € 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: s after dec. filled in by 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cealm who completed cause of death (Item 23a) (Type, Print) ame and address of person Vacem 31. Date filed (Month, Day, Ye egistrar's Signature Year) State Registrar DHMH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3/2 in/2 of 190 ft 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Sylvia Brooks July 2005 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner of Manyland Medical Genter Baltimore NIA 5. Social Security Sumber 6. Sax If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 💢 F 215-32-5011 Usual Residence of Decedent MAR Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mandal Hygiene.
sent of Health and Mandal Hygiene.
sent: If items 27 is marked other then "naturel", or items 23a or 28e-f show any or other treumetic event, if is Mandal Examinar must be nullified at 1XYes 2 No Completed by Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 908 ROAD EDRIC USA, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12 nentary/Secondary (0-12) College (1-4or 5+) NURSING HOME NURSES AID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BROOKS 2 NATHANIEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAVANNAH DRIVE NICITOLAS KENTUCKY 40356 ECIL HOLL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of importent: If any injury or once. 07-15-05 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FAPILITY BROWN JR, FUNERAL HOME 21. Signature of Funeral Serviçe Licensee BALTO, MD. 21217 FULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician Cancer Breast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending to the time of the time. that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 10 2 ER/Outpatient 3 DOA 27. Manner of Death

1 XNatural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif th (Item 23a) (Type, Print) 30. Name and address of South Greene Street Baltimore, MD 21201 Damm 32. Registrar's Signature 31. Date filed (Nanth, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please	e Type or Print in E	Black Ind	lelible Ink	. Ensu	ıre Al	l Copies	Are	Legible.	
_ For	State of Marylan					-		_	
1 - State Registrar	•		tificate of				Reg. No.	_	
Decedent's Name (First, Middle, L.	ast)					2. Date of De		2005	Trans of Deaths
Erika	Ε.	Born				Month	Day	Year	4120 AM
4a. Facility Name (If not institution, gi		DOLII	4b. City, Town, o	or Location	of Death		4c.	County of Deat	h
BALTIMORE WAS	11 4	SNTER		N BU		FE	Λ		2UNDEL
5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign
219-30-0084	1□ M 2124F 97	Yrs.	Months Days	Hours	Min.	Dec. 3		Co	untry)
Usual Residence of Decedent	71.					Dec.	, 1	907 Es	stonia
10a. State 10b. County	10c. Cit	ty, Town or Loc	ation						10d. Inside City Limits
Maryland Anne_A	rundel Pag	sadena							1 ☐ Yes 2 ☐ No
10e. Street and Number	Tunuci Ta	зачена	10f. Zip Code				10g. Citi	zen of What Co	untry?
624 Sutton Drive			211	22				U.S.A	
11. Marital Status	12. Was Decedent Ever in U		as Decedent of I	Hispanic Ori	igin? (Sp	ecify Yes or No		14. Race - Ame	rican Indian,
1 Never Married 2 Married			Yes, specify Cub			Rican, etc.)		Black, White	e, etc.
3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:				Specify:	hite
15. Decedent's I	Education	16a. Decede	ent's Usual Occu	pation			16b. Ki	nd of Business/	
(Specify only highest g	College (1-4 or 5+)	life. D	rind of work done O NOT use retire	<i>dunng</i> mos d)	it of work	ing			
6	N/A	Н	ousewife					Own H	OMA
17. Father's Name (First, Middle, Las	it)				er's Name	e (First, Middle,	Maiden		Oile
Jaan		Kalm		Wi1	helm	ine			Hergauk
19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street				er, City o	r Town, State, Z	
Heino Born (Son)		624	Sutton D	rivo	Paca	dono M	n var 1	ond 211	22
20a. Method of Disposition	20b. F	Place of Dispos	ition (Name of atory or other pla			Date		cation - City or	Town, State
1 ☐ 5urial 2 ☐ Cremation 3 1 ☐ 4 ☐ Donation 5 ☐ Other (Spec	☐Hemovai from State	-	en Mem.	' 1	7/1	5/05	01-	- D	- M 1 1
21. Signature of Funeral Service Lice			Name and Addre	,		3/03	GTE	n Burni	e, Maryland
1 1 -	- 111					Euneral	Hom	e. P.A.	nd 21122
23a. Part1 Inter the disease, or col	molications that caused the deat							Maryla	nd 21122
shock, or heart failure. List onl	y one cause on each line.	in. Do not ente	i the mode of dy	ng, such as	cardiaç (or respiratory a	ilest,		Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a Sebal	۵							Shoot and Boan
resulting in death)	Due to (or as a conseq	quence of):	1	8	Ď.				
Sequentially list conditions.	6 Wrinary	Trae	t	hec	lion	*			
Sequentially list conditions, if any, leading to immediate cause. Lines Uridenying Cause (Disease or injury	Due to (or as a conseq	quence of):		1					
that initiated events	c. Dehy	halis	~						
resulting in death) Last	Due to (or as a conseq	quence of):	1	(
	d. Houte	Rena	l fa	سللاه					
le recons									
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc				2	23d. Date of deli	ivery
in the past 12 months?	4☐Pregnant at time of d		Other (specify) _	у	_			Month	Day Year
9 Unknown	9□ Unknown								
Part II. Other significant conditions	· F 1		derlying cause gr	ven in Part I	l.	23e. Did t	obacco u	se contribute to	the cause of death?
Aorte	e stenosi	-8				1 🗆 '	Yes 2	No 3□Pr	obably 4 Unknown
i	le bothu	lism				24a. Was	an	24h Wara au	toney findings available
	the makes					autor		prior to death?	topsy findings available completion of cause of
	Hy berte is	col-				1 ☐ Yes	2 No	1 Yes	2 No
25. Was case referred to medical examiner?	Hospital:		04		e of Death	(Check only o	ne)	-	
1 ☐ Yes 2 № No	Hospital: 1 Minnatient 2	EB/Outpatient	3 DOA C8	ner: 4 🗆 Ni	recipa Ho	mo E Posi	dence 6	Other (See	:4.1

Physician /Medical **Examiner**

Physician /Medical

Examiner

Director

Funerai

Completed by

To Be

Funeral

Director

27. Manner of Death

1 🗷 Natural

2 Accident

4 - Homicide

(Check only one)

31. Date filled (Month, Day, Year)

3 Suicide

29a. Certifier

Examine Physician/Medical þ Be Completed Certification; To

The Mappitel or Attending Physicien: The law requires that the deeth certificate be executed As Ab rours after death.

For Euneral Director: After this certificate has been signed by the ettending physicien and letterly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 hou To the Fune completely fil	Medical
To the within To the compl	Me
19	2
2	
s	tate

Registrar

29b. Signature and title of certifier Jayashru

5 Pending

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

146596

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

Tay whree Amble Battemore

JUL 1 3 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:05 PM gth Garland <u>Black</u> 2005 Mark /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMORE WA 6. Sex ReliCAL Year CENTER HRUNde 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 № 2 □ F Days Hours Min. **Director** 224-58-2832 60 Sept. 8,1944 North Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23e or 28a-f show traumatic avant, the Modical Examiner must be natified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23e or: 2205 229th Street 21122 Funerai <u>U.S.A.</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 N/AAuto Technician Admiral Pontiac 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garland Mayfield **Black** 2 Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or othar traignee. Alice Louise Black (Wife) 2205 229th Street Pasadena Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Pk. 07/ 12 /05 | Glen Burnie, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. Willing 3204 Mountain Road Pasadena, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, lany, bearing to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown ģ LACK, GAIZLANI Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 **X**No 1 Tyes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation M within 24 hours after death To tha Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \[Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Dr., Glen

1 am

31. Date filed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of M	arylanu /	Certificate of	rieaith and Menta ^r Death		00000			
			1. Decedent's Name (First, Middle, L	ast)	COMMODIC OF	2. Da	Reg. No. 2 te of Death	3. Time of Dealin				
	Physici /Medio		Jefferson H	urgess			Mo	UN 47h 2	1005 113 Am			
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or Location	of Death 4c. County	of Death			
			St Thomas More	NUrsing Ho	ome		Hyattsville		(G)			
	Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last bi	Months Davs		te of Birth Onth, Day, Year) 7 18 20	Birthplace (State or Foreign Country)			
	Director		248-28-5729 Usual Residence of Decedent		84	Yrs.	0.	/ 18 20	North Carolina			
	land ow		10a. State 10b. County		10c. City, Tov	n or Location			10d. Inside City Limits			
	Mary Fish	호	DC		Wash	nington			1. Yes 2 □ No			
	h the	irec	10e. Street and Number			10f. Zip Code		10g. Citizen of V	What Country?			
	th will	Funeral Director	912 D Street N.	E.		20002	2	USA				
	en dea	ne.	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of	Hispanic Origin? (Specify Yesan, Mexican, Puerto Rican,	es or No-	e - American Indian, ck, White, etc.			
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 Is marked other then "neturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🖾 No			Black			
Ď	2 hou	Completed	15. Decedent's E	ducation	16a	. Decedent's Usual Occu	pation	16b. Kind of Bu	usiness/Industry			
7	thin 7 e. en "n	ag l	(Specify only highest gi	College (1-4or	5+)		during most of working ad)					
2	filed wi Hygien other th	ပ္ပ	12th		Fo	ood Service			Reed Medical Ctr			
and and	be fill d oth	Be	17. Father's Name (First, Middle, Las	")			18. Mother's Name (First, Middle, Maiden Surname)					
출	should I	ဥ	Davis Burgess				Louvenia Bu					
Ma	d 2 st th end 7 is n traur		19a. Informant's Name/Relationship				at and Number or Rural Route	•	State, Zip Code)			
Ġ,	Healt Healt other		David Walcott/Ne 20a. Method of Disposition	pnew		of Dingre St of Disposition (Name of ony, crematory or other pla	Sumter, SC.		City or Town, State			
ō	Peges nent of I unt: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec.			ny, crematory or other pla 1n Memorial						
Baltimore,	nit. Pertme ortan Injur		21. Signature of Funeral Service Lice		Linco		orial Cem. 7-12-05 Suitland, MD. and Address of Facility MArshall's Funeral Home					
å	Depe Impo any It	N (Demand	Rall.	St. N.W. Was	shington, D.	C. 20011					
			23a. Parri Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not enter the mode of dy	ing, such as cardiac or respi	ratory arrest,	Approximate Interval Between			
1	Physician						4	N	Onset and Death			
ĺ	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Como	NICO	2557ru	thre low	e Distas	H YEAR			
		-	,		Due to (or es e	consequence of):)	/			
	uted	Aedical Examiner		b	Due to for so a	consequence of):			-			
oʻ.	tificete be executed g physician end es the buriel-trensit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a	consequence oi):						
68760,	ite be iysicia ne bu	Cal	flame (Linease or injury) that initiated events resulting in death) Last	0.	Due to (or as a	consequence of):						
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Box	eth ce ttendi	Physician/		d								
о. О.	the e	yslc	Part II. Other algnificant conditions	contributing to death b	ut not resulting i	n the underlying cause gi	ven in Part I. 23	b. Did tobacco use cor	stribute to the cause of death?			
	The law requires thet the deeth certificate be exacuted ete has been signed by the ettending physician end pege 2 should be deteched for use as the buriel-trensit	Y P	Dements	3				1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown			
rds	puires n sign ald be	d by	and the	111	115	20	24	a. Was an autopsy	24b. Were autopsy findings			
ပ္ပ	w rec s bee	ete	PUNDE 14	1 100	wi	<u> </u>		performed?	available prior to completion of cause of death?			
8	he la te hes ege 2	Completed	the per	tensi	on			1 ☐ Yes 2 ₹ No	1 ☐ Yes 2 ☐ No			
a	rsician: The law s certificete hes b director, pege 2 s	Bec	25. Was case referred to medical		1		26. Place of Death (Chec		12.00 22.10			
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0 0	ng Ph ter th meral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of 28c. Inju		scribe how injury occurr				
Sio	endir eath. or: Al	catic	2 Accident investigation			M 1]Yes 2□No					
Division of Vital Records,	or Att efter d Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could not to determined			ırm, street, factory, office		ation (Street and Number or Town, State)	er or Rural Route Number,			
_	To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		2lis Certifor 1 *Certifolog El	welclan: To the best	of my knowledge	doub occurred at the tr	me, date and place, and due	to the agreealet and con-	or an etal-of			
	e Hos 24 h Fun letely	edical	(Check only 2 Medical Exa	niner: On the basis of and manner sta	examination an	d/or investigation, in my	opinion, death occurred at the	e time, date and place, a	and due to the cause(s)			
	withir To th	Z e	29b. Signature and title of certifier	1	1 ,	29o Licens	se number	29d. Date signed	(Month, Day, Year)			
	1	/	Mul	len Ill	M	1 W	01852	July 5	5 2005			
	10		30 Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Print)	my Rd Hy					
	V		31. Date filed (Month, Day, Year)	32 Regietr	ar's Signature	ru reason	714 114	7 13302 117	W 20 707			
	Sta Registr		JUL 132	AZ	e B	Grade						
			All the last time to		-	- 4						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 **Physician** Stephen F. Beckenholdt July 10. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8503 Dempster Ct. Apt. E Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. B, 1947 Birthplace (State or Foreign Country) Funeral Days Hours 1**⊠**M 2□F Yrs. Director 281-44-7287 57 Indiana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
and: If tiem 27 is marked other than "netural", or iteme 23a or 28a-1 show and: If item 27 is marked other than "netural", or hiteme 23a or 28a-1 show any or other traumatic event, Ine Medical Examinar in tun be, notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Md. Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8503 Dempster Ct. Apt. E 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Associate Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Theodore W. Beckenholdt Phyllis Syring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Kiersten Poss/Daughter 2459 Warm Spring Way Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.!7/12/05 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1050 York Road Towson, Marvland 21204 Approximate Interval Between Inset and Death Immediate Cause (Final Metastatic Adenocationoma **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should Be Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 2 40 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Matural 5 Pending after death. Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) Oncolug 1) inlacer Hame and addr s of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Suite 203 6569 Kobert 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Centificate of Death Reg. No. 2005 2280
1	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Whoolty 9, 2005ar 9:59P. M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NORTHWEST HOSPITAL CENTER 4c. County of Death RANDALLSTOWN BALTIMORE
¥	Funeral Director		5. Social Security Number 240-54-0967 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday)
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 Yes
	h with the 23a or 28s	Funeral Director	10e. Street and Number 3409 Crovdon Road 10f. Zip Code 21207 10g. Citizen of What Country? USA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. Item arked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinat must be notilised at	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: Specify: Specify:
រភ	within 72 hou ene. then "natura he Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT us oretired) 16b. Kind of Business/Industry Life DO NOT us oretired)
	ould be filed with Mental Hygiene. arked other the atic event, Inc.	o Be	17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) LUCY Wason
2	1 and 2 shoul Health and M Iem 27 Ie mari other traumati	-	19. Informant's Name/Relationship (Tyle, Print) 19b. Mailing Admess (Street and Number or Ryll Route Nimber City or Town, State, Zip Code) Nichelle Ford Daughter 6971 Kockfields Rds Window Mill UD 2124
Baltimore,	90 = 5		20a. Method of Disposition Method of Disposition 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 7 19 05 06 06 06 06 06 06 06
Bal	permit. Pag Department Important: eny injury o		21. sprand of Funeral Service Service of State of Red Red Service of Rules of Red Red Red Red Red Red Red Red Red Red
	Physician		23a. Part1. Since the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition Approximate Interval Between Onset and Death disease or condition
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O. Box 68	The law requires thet the death certificate be existence been signed by the attending physicien page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 4 Month Day Year 5 Other (specify)
rds, P.O	w requires thet the death been signed by the atter should be detached for	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Il Records,	The law receive has bee page 2 sho	Completed	24a. Was an autopsy performed? 1 Yes 2 \(\subseteq \) No 24b. Were autopsy findings available prior to completion of cause of death?
l Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? Yes 2 No Hospital: 1 Xinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division of	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 3 Security 6 Could not be
Divi	urs after or At urs after or ral Direc	Certifi	4 Homicide determined determined building, etc. (Specify)
	he Hosp in 24 hor he Fune pletely fi	edical	29a. Certifier Careck only Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	with To 1	×	29b. Signatur and tive of certifier 29c. License number OCME 29d. Date signed (Month, Day, Year) JULY 10, 2005
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201
-	Sta Regist		31. Date filed (Month, Day, Year) 32 Registrar's Signature 33 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Uhn 2:55 p M Ju1v 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 27, 1926 Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2 ☐ F 79 Yrs. Director 067-18-6927 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28s-f ehow 1 ☐ Yes 2 🛱 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1909 Harwood Road 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1944–78 1 Never Married 2 XMarried 1 ☐ Yes 2 No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other then 'eny Injury or other traumatic event. If a Me College (1-4or 5+) Elementary/Secondary (0-12) Captain U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Melville Bajus Edith O. Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne May Bajus (Wife) 1909 Harwood Road, Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 9/16/2005 Arlington, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, DM 21401 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) set and Death **Physician** intra cerebral homorrhore /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown should I tria 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s rmed? 2 No certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D24804 lever MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMIC Petorso . Registrar's Signature 31. Date filed (Month, Day, Year)

JUL 1 3 2005 State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	-4)		Cer	tificate	of D	eath		Re 2. Date of Deat	g. No. 2	005	22	81
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Examir		4a. Facility Name (If not institution, giv	e street and number) MEMORIAL H	OSPIT	ΔΙ	4b. City, 1	D. City, Town, or Location of Death BALTIMORE				4c. County of Death			
uneral irector		Social Security Number 6. 3		e (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birth (Month, Day, Jun 23,	Year) 195 2005	9. Birthp	place (State ontry) MD	or Foreig
how		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, To wn or Lo	cation					10d. Inside City Lim			•
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od other than "naturel", or Items 23a or 28a-f show svent, the Medical Exactinat mail to notified at	Completed by Funeral Director	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 201 If Yes, Give Year or Dates:		1	 13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: 						lace - Ameri lack, White, cify:		
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27 Is ma r trauma		19a. Informant's Name/Relationship (GREGORY BREWER	**	BROTHER 517			•			Route Number,	,		,	
ent of need nt: If Item 2 ry or other		20a. Method of Disposition 1 Burial 7 Cremation 3 C 4 Dopation 5 Other (Special		0	Place of Dispo emetery, cren	natory`or ot	her place		Da AL 0	7/08/05		n - City or To		
Important: If Ite any Injury or of once.		21. Signature of Fuer I Service Lice	1		22	. Name and	ler"s N	fetropo	litan C	hapel P.C. Baltimore		104040		
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ttending or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											Date of delive		Year
signed by the a d be detached f	by	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying ca	use give	n in Part I.				ontribute to the	he cause of coably 4	death? Unknow
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im. r: After this certitica e tuneral director, p		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		3c. Injury Work	at	28	3d. Describe ho			,,	
within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification;	3 Suicide 6 Could not be determined		jury - At ho	ome, farm, str y)	eet, factory	, office		21	Bf. Location (Sti City or Town		mber or Rura	al Route Num	ber,
ne Funera Jetely filk	edical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	nysician: To the best miner: On the basis o and manner st	of examina	wledge, death	occurred a vestigation,	t the time in my opi	e, date and inion, death	place, <i>at</i> n occurre	nd due to the ca d at the time, da	use(s) and ite and plac	manner as s e, and due to	tated. the cause(s	5)
To th comp	Me	29b. Signature and title of certifier				29c.	. License	number		29		ned (Month,		
		30. Name and address of person who	completed cause of completed cause of completed cause of completed cause of complete cause of cause cause of cause cause of cause ca	leath (Iten	7. 22a) (Tuna	D	005	2391		70	uly 3	3, 200	5 Sity PK ZIZI8	
0		30. Name and address of person who	completed cause of c	Joann (Iron	1 23a) (Type,	Print)				20	, -		ariri B K	wa

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Registrar

			State of Maryland / Department of State of State of		Mental Hygi	ene						
			1. Decedent's Name (First, Middle, Last)	or Death	2. Date of Deatl	9. No. 2005	3 Time of Death?					
F	hysici		Norene S. Barlow		JULY Month	7, Day 2005 Year	5:53p M					
8	/Medic Examin			wn, or Location of Death		4c. County of Dea	ith					
	* 4,	Falls	1095 Skyway Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1.	Annapolis Year If Under 24 Hrs.	8. Date of Birth		Arundel					
	uneral rector		125-36-5426 1□M 2∏F 59 Yrs. Months □	Days Hours Min.	oct 29,	1945 Ne	thplace (State or Foreign ountry) WYORK					
land	Mo M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
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ith th	or 28	Dire	10e. Street and Number 10f. Zip Co		10	g. Citizen of What C						
eath v	ns 23e	Funeral Director	1095 Skyway Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden	21401	ecify Yes or No-	USA 14. Race - Am						
U Z IZ 13-0000 filed within 72 hours after death with the Maryland Hygiene.	Importent: If item 27 is marked other than "naturel", or items 23s or 28e-f ehow any injury or other treumatic event, it e Medical Even front must be notified all page.	by Fun	Armed Forces? If Yes, specify 1 Never Married 2 Married 1 Yes 2 No If Yes, Specify 1 Yes, specify 1 Yes, specify 1 Yes, specify 1 Yes, specify 1 Yes, specify 1 Yes, specify 1 Yes, specify 1 Yes, specify	nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	Rican, etc.)	Black, Whi						
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2 shc	reum reum			Street and Number or Run			Zip Code)					
1 and Healtl	tem 2		Stuart S. Barlow/husband 1095 Skywar 20a. Method of Disposition (Name 20b. Place of Disposition (Name	of I	napolis,	MD 21401 Oc. Location - City or	Town, State					
Pages ment of	tent: if i		1 Burial Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Burial Crematory or other Metro Crematory	y, Inc. 7/8,	/05	Baltimor						
Dermit Depar	any in		21. Signature of Funela Service Libers of Maryland, Inc. Dawn F. McDonald 22. Name and Address of Facility of Maryland, Inc. 299 Frederick Road Baltimore, MD 2122									
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode o shock, or heart failure. List only one cause on each line.	of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Opset and Death					
	sician edical		Immediate Cause (Final disease or condition resulting in death) a. Ure fem Cancer Due to (or as a consequence of):				64ears					
	miner											
nted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
icate be exec	physician and is the burial-transit		resulting in death) Last Due to (or as a consequence of):									
ificate	g phys	edlcal	d									
th cert	r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1	nancy		23d. Date of de						
the dea	been signed by the attending should be detached for use a	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown 1 ☐ Other (special polyment)			Month	Day Year					
es that	igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.			o the cause of death?					
requires	peen s	eted				•	robably 4 Unknown					
The law requires that the death certificate be executed	this certificate has t al director, page 2 s	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of					
VICION	certific rector,	Be	25. Was case referred to medical examiner?	Other	h (Check only one							
P P	er this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c.	. Injury at	28d. Describe ho	nce 6 Other (Spe w injury occurred	ecify)					
endin sath.	or: Aft he fun	atlo	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	Work? 1 ☐ Yes 2 ☐ No								
of or Atte	Direct d in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, or building, etc. (Specify)	ffice	28f. Location (Str City or Town,	eet and Number or R State)	ural Route Number,					
To the Hospitel or Attending Physicien: within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at to the basis of examination and/or investigation, in and manner stated.	the time, date and place, my opinion, death occurr	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)					
To the	To the comp	Ž		icense number	29	d. Date signed (Mon	th, Day, Year)					
1	N			14576		+18105						
6			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 or leans freet Boltmore MD	21231								
	Sta Registr		31. Date filed (Mong Pay, Year 2005) 33. Registrar's Signature									

		1 - For Registrar	State of Ma	•	epartment of Certificate o		d Mental Hy	giene Reg. No.	2110	5 22	010
		Decedent's Name (First, Middle, Last)		·		2. Date of Da Month	ath Day	Year	3. Time o	n Death
Physic /Medi		Margaret Rosalee B	erger				July	11,		1:00	A M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of D	Death	4c. C	ounty of Death		
		652 Charraway Road			Balti				/a		
Funeral		5. Social Security Number 6. Se	x 7.Age ∃M 2√2 F	(In yrs. last birth	day) If Under 1 Ye Months Da		Min. (Month, Da	y, Year)	Con	place (State intry)	or Foreign
Director		217–26–4788 Usual Residence of Decedent	*	74''			July 4,	193	1 Mar	yland	
land ow		10a. State 10b. County		10c. City, Town	or Location					10d. Inside C	City Limits
Many	to	Maryland n/a		Baltimo	re					1 y Yes	2 □ No
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-f show eumatic event, the Medical Examinar must be notified at	Director	10e. Street and Number			10f. Zip Cod	9		10g. Citizen of What Country?			
th wit	aiD	652 Charraway Road			212	29		Unite	ed Stat	es	
ems	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decedent	of Hispanic Origin uban, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	- 14	I. Race - Amer Black, White		
within 72 hours after ene. than "natural", or ite	by F.	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give	lo	1 ☐ Yes 2 X	lo Specify:		s	Specify: W	nite	
hours tural:		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	162 [Decedent's Usual Oc	cupation		16h King	d of Business/l	nduetry	
n 72	Completed	(Specify only highest grad	le completed)	(Give kind of work do life. DO NOT use re	ne during most of	f working	TOD, KIIK	201 20311103371	idustry	
with iene r ther	E	Elementary/Secondary (0-12)	College (1-4or 5-		ousewife				home		
filed Hygi other	BeC	17. Father's Name (First, Middle, Last)	0			18. Mother's	Name (First, Middle	Maiden S			
should be and Mental marked o	TO B	Hunter Robinson				Marie	Hines				
s 1 and 2 should f Health and Mer ftem 27 is marke other treumatic		19a. Informant's Name/Relationship (T					or Rural Route Numb				
127 g		Thomas Berger, Sr.	- husband		1.00		Baltimore	, Mai	ryland	21229	
of Head		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of I cemetery	Disposition (Name or r, crematory or other	olace)	Date	20c. Loca	ation - City or T	own, State	
Pag Pag Int:		'4 Donation 5 Dother (Specify		Loudon	Park Ceme	etery 7/	15/2005	Balt	more,	Maryla	ind
permit. Departminimporta		21. Signature of Funeral Service Licent	2 1		22. Name and Ad	dress of Facility	Hubbard Fu	inera.	l Home,	Inc.	
70 E 9 9	page.	runny.	xnx		4107 Wil	cens Ave	nue, Balti	more,	, Maryl		
		23a. Part1. Enter the disease, or composition of shock, or heart failure. List only (lications that caused one cause on each lin	the death. Do no le.	ot enter the mode of	tying, such as ca	rdiac or respiratory a	rrest,		Approxima Interval Be Onset and	tween
Enysician		Immediate Cause (Final disease or condition	cong	chlus	Hear	Tan	Ru			1 Jh	- Deaul
/Medical Examiner		resulting in death)	Due to (or	a consequence of	f):	0	,	2 11.64			
LXammer		Sequentially list conditions,	b. coro	nary	arter	4	sees			14/2	
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter out of high Cause (Disease or injury	Due to (or as a	a consequence of	1):						
sate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	f);						
cate be executed obysician and the burial-transit			_								
ficate phys	edicai		d		**. *.						
The law requires that the death certific site has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23	3d. Date of deli-	very	
death s atte	cial	in the past 12 months?	4 Pregnant at	2 Fetal death time of death	3 ☐Ectopic pregna 5 ☐ Other (specify				Month	Day	Year
that the de led by the a detached	hys	9 🗆 Unknowh	9□ Unknown								
es tha igned to be det	by P	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the underlying cause	given in Part I.	23e. Did 1	obacco us	e contribute to	the cause of	death?
v require been sig should t		Dele	les Mi	ellele			1□	Yes 218	No 3□Pro	bably 4 []Unknown
law requas been 2 should	piet						24a. Was		24b. Were aut	opsy findings	available
The lav	Completed						perfo 1 ☐ Yes	ormed?	death?	2 No	
ian: artifica	Be	25. Was case referred to medical examiner?				26. Place of	f Death (Check only				
Physician: rthis certific ral director,	To	1 Yes 2 No	Hospital: 1 ☐ Inpatie		patient 3 DOA		ing Home 🏻 🛣 Resi	dence 6	Other (Spec	ify)	
ng PI fter th		27. Manner of Death 1□ 1□ 2 1□ 2 1□ 2 1□ 2 1□ 2 1□ 2 1□ 2	28a. Date of Injui	ry 28b. Ti y Year) In		njury at Work?	28d. Describe	how injury	occurred		
Attending r death. ector: After by the fune	Certification:	2 Accident investigation				Yes 2 No		_			
i or Att after d Direct i in by t	ŧ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, far c. <i>(Specify)</i>	m, street, factory, off	Ce	28f. Location (City or To		Number or Ru	ral Route Nur	m <i>ber</i> ,
urs af urs af ural D				-			U				
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exen	ysician: To the best	examination and							(s)
thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner sta	1180.	29c Lie	ense number		29d. Date	signed (Month	Day, Year)	
T W S		Do. Signature and title of defined	20		2	^		7/1	1./	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
,		00 11/10	completed course of d	leath (Itom CO-)	Type Print)	2304	4	(/ L	19		
5		30. Name and address of person who	A.A.		Type, Print) MMM	1 Fens	n Rel	PAT	SV M	2	22
	tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	- Mylan	1-10	1	1140	1-1-12		-/
Regis		JUL 1 3	ZULIS NO	BLAND S	GONES!						

State of Maryland / Department of Health and Mental Hygiene

			AMEND ITEM #5 PER FH G845 7/22/09/e of Death		Reg. No. 2	005	22011							
	Dhuninin		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Dey	Year	3 Time of earl							
4	Physicia: /Medica		Charles William Barton	July :			7:00 PM							
	Examine		4a Fecifity Neme (If not institution, give street end number) 4b. City, Town, or Lo			inty of Deeth								
			7427 St. Patricia Court Dundal	k	F	altimo	re							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da			place (State or Foreign							
	Director		3323 214-30-3-3-6- 1□xM 2□ F 71 Yrs. Months Deys Hours Min. Vrs. Vrs. Worths Deys Hours Min. Vrs. Vrs. Vrs. Worths Deys Hours Min. Vrs. Vrs. Vrs. Vrs. Vrs. Vrs. Vrs. Vrs	Sept.			t Virginia							
	pue M		10a. Stete 10b. County 10c. City, Town or Location			1	0d. Inside City Limits							
	the Meryler 28a-f show	cto	Maryland Baltimore Dundalk				1 ☐ Yes 2 ☒ No							
		Funeral Director	10e. Street end Number 7427 St. Patricia Court 10f. Zip Code 21222			of What Cour ed Sta								
	ge a g	ē	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	- 14.	Race - Americ								
21215-0020	72 hours efter death with "neturel", or frems 23s or edical Evandrer must be		1 Never Married 2 Married 1 Yes, Sve 1 Yes, Give 1 Yes 2 No If Yes, Give Year or Dates:	riican, eic.)		Black, White, ec <i>ify:</i> W	eic. hite							
ğ	natural',	Completed by	15. Decedent's Education 16e. Decedent's Usual Occupation		16b. Kind o	of Business/Inc								
21	within 7 ene. then "n	be	(Specify only highest grade completed) Elementery/Secondary (0-12) Coflege (1-4or 5+) Elementery/Secondary (0-12) Coflege (1-4or 5+)	ing										
21	and and and and and and and and and and	E	8 Years Inspector		Ame	rican	Can Co.							
D	at the		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,										
an	should be in marked of umatic eve	o Be	Albert George Barton Leo	na Gerti	rude W	Tright								
2	d Mer	2	The second secon				Codel							
Maryland	pemit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if item 27 is merked other than any injury or other traumetic event, the Monte.	-	19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7427 St. Patricia Court Dundalk, Maryland 21222											
	teath 1 teath 1 teath 2 the 2 the 2 the 2 the 2 the 2 the 2 the 2 the 2 the 2 the 3	-	20a. Method of Disposition 20b. Place of Disposition (Name of	Date										
Baltimore,	ges tot interest		Page of Disposition 1 2 Cremation 3 Removal from State	Date	200. Locali	on - City or To	wn, State							
Ë	Bant;		4 □ Donetion 5 □ Other (Specify) Holly Hill Mem. Gdns. 7/1	15/2005	Mid	ldle Ri	ver, MD							
<u>=</u>	permit. Depertimport		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral	Home o	f Dund	lalk T	nc							
m	89 2 2 9		7922 Wise Ave. Dr			-	1222							
		\dashv	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			and 2	Approximate							
	Dhunisian		shock, or heart failure. List only one cause on eech line.				Interval Between Onset and Death							
	Physician /Medical		Immediate Ceuse (Final			1	1							
5	Examiner		disease or condition resulting in death) a. Tancrectic (ancer			1	1 year							
и		_	Due to (or as a consequence of):			1	·							
	Pa # 1	=	b			1								
	rificete be executed ng physicien end es the buriel-trensit	E	Sequentiaffy list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.											
68760,	Se ex	<u> </u>	Cause. Disease or injury											
376	ete b hysic the b	S	that initiated events resulting in death) Last Due to (or as a consequence of):			1								
	The lew requires that the death certificate be executed at has been signed by the ettending physicien end page 2 should be deteched for use as the bunial-trensit	Medicai Examiner				1								
Box	h ce endii	30	d			-								
	deat deat	<u> </u>	Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	obacco use	contribute to	the cause of death?							
P.0	the eche	Physician		101		/	pably 4 Unknown							
	thed a det	9	Diabetes Mellitus		03 201	0 0	4 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
of Vital Records,	v requires thet the death ce been signed by the ettendii should be deteched for use	D		24a. Was	an autopsy	24b. We	ere autopsy findings							
S	raq beer shou	Completed	Coronary Hrteny Disease		med?	CO	ailable prior to impletion of cause							
ě	has ge 2	린				of	deeth?							
=	Page 2	5		1□ Y	es 2 N	0 10	Yes 2□ No							
ij	certificate rector, pag	D C	25. Was case referred to medical examiner? 26. Pface of Deat	h (Check only o	ne)									
=	nysk sis of dire	2	1 Yes 2 No Hospital: 1 mpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 51 Resid	ence 6 🗆	Other (Specif)	1)							
0	Attanding Physician: r death. sctor: After this certific by the funerel director,		27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Work?	28d. Describe h	ow injury oc	curred								
<u>ō</u>	ath.	atic	2 Accident investigation M 1 ☐ Yes 2 ☐ No											
Division	Atta	Certification:				mber or Rura	l Route Number,							
ā	d in die	9	building, etc. (Specify)	City or Tow	11, 31616)									
	spitu nours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place,	and due to the	ause(s) and	manner as st	ated.							
	P Fur	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, o	date and pla	ce, and due to	the cause(s)							
	To the Hospital or Attanding Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29b. Signature end title of certifier / 29c. License number		29d. Date sid	gned (Month,	Day, Year)							
	F 3 F ŏ		1 1 1 (411)				_							
	10		he halle 1toussag2		Ju 14	12,	2005							
ľ	of 1		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	. 1	W 4	^ =	13.3.4							
7	<u> </u>			Itimo	e, M	N 3	11777							
1	State		31. Date filed (Month, Day, Year) 32. Registrer's Signature											
£-	Registra	*	1111 1 3 200 Reason 15 Coaste											

Registrar

			For State Registrar	State of M	/larylan		artment rtificate			and M		jiene	000	000.	
	1.4		Decedent's Name (First, Middle, III)	Last)							2. Date of Dea Month	th	005	Time (Death)	
<	Physici /Medic		Thelma V. Bond								July	12,	2005	1:50 p ^M	
	Examin		4a. Facility Name (If not institution, g	give street and number	r)				Location o	of Death		4c. Coi	unty of Death		
E.			Bonds Forest As: 5, Social Security Number 6			land himbola.	Fink		rg If Under:	24 Hrs	8 Data of Birth		Carro		
г	Funeral Director		214-01-3221	1 M 2 XF	101	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day)	, Year)	9. Birthp	place (State or Foreign htry)	
- (4)			Usual Residence of Decedent								une 0,1	. 304		MD	
	ahow	_	10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits	
	8a-1 s	Director	MD Baltin	nore		Glynd								1 ☐ Yes 2 X No	
	with the sor 2	ä	10e. Street and Number				10f. Zip (tizen of What Country? USA		
	leath ns 23	Funeral	4238 Butler Roa	12. Was Deceder	nt Ever in U.	S. 13.	Was Decede	2107 ent of His		gin? (Spe	cify Yes or No-		A. Race - Americ	an Indian,	
9	after dea or items	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces		i				i, Puerto F	Rican, etc.)		Bleck, White,	etc.	
93	in 72 hours after death with the Maryland "natural", or Items 23s or 28a-1 ahow ofted Expoliser must be rediffed at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1□Yes 2	TATINO	Specify:					nite	
21215-0036	"natu	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual kind of work DO NOT use	done d	urina most	t of workin	g	16b. Kind	of Business/Ind	dustry	
12	filed within Hygiene.	dwo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		nstres	,				Set	wing		
	should be filed within 72 ho Id Mental Hygiene. marked other than "natu matic event, the Hedical	a	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle,			· · ·	
/lar		To B	Morris Biddle						Ly	dia (O'Brien				
Maryland	S a s		19a. Informant's Name/Relationship	(Type, Print)		1		•			Route Number			Code)	
	other tr		William H. Bond 20a. Method of Disposition	Son	20h P	211 I			ad, R		erstown		21136 on - City or To	Ctate	
Jo.	0 0		1 ☑ Burial 2 ☐ Cremation 3		te a	emetery, cre	matory`or ott	her place	, 1						
Baltimore,	T E 5 5		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie		LOI	raine	Park 2. Name and	Addres:		7/17,			lawn, M		
B	Departiment of the concession		18am 13 0	Ilma	2		line F			-		824 Reisterstown Road isterstown, MD 21136			
10	· · ·		23a. Part1. Enter the disease, or co shock, or heart failure. List or	inplications that caus	ed the death	n. Do not en	ter the mode	of dying	, such as	cardiac o				Approximate Interval Between	
	Pnysician		Im rediate Cause (Final ease or condition	-	rcino	ma	of H	u f	3/2/	12				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):	,						1		
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequ	uence of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,	, .									
o,	an and rial-tra	Еха	resulting in death) Last	c Due to (or a	s a consequ	uence of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	licai		d											
9	eath certifica attending ph for use as ti	Physician/Med	IF FEMALE:	23c. If yes, outcom	an of pregna	IDOV.									
Вох	atten for us	cian	23b. Was decedent pregrant in the past 12 months?	1 ☐ Live birth	2 Feta	death 3	Ectopic pre Other (spe					230.	Date of delive Month	Day Year	
0	tilhe d ay the	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown											
S, P	res that the de signed by the a be detached t	by P	Part II. Other significant condition	s contributing to death	but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	cootribute to th	ne cause of death?	
ecords,	w require been si should b										1 🗆 Y	es 2 N	o 3 🗆 Prob	ably 4 Unknown	
ec	elawi hasbu	Completed									24a. Was a autops	sy /	prior to cor	psy findings available npletion of cause of	
al B											1	2 No	death?	2□ No	
Vital	Physician: r this certificatal director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tiont 2	ER/Outpatie	nt 3 🗆 DOA	Othe	_		(Check only or ne 5 ☐ Reside			Assitu	
		H- 1	27. Mann of Death	28a. Date of In (Month, L		28b. Time o		c. Injury Work		-	8d. Describe h			Living	
ion	Attending F r death. sctor: After by the funer	atlo	1 Accident 5 Pending investiga	tion	Jay 16ai)	Injury	М		r /es 2 🗆 l	No					
Division	I or Attendate death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 280. Place of I	njury - At ho etc. <i>(Specil</i>)	ome, farm, st	reet, factory,	office		2	8f. Location (S City or Town	treet and Ni n. State)	umber or Rura	l Route Number,	
	urs af urs af eral D														
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Expone)	Physicien: To the best aminer: On the basis and manner	of examina	wiedge, deat tion and/or in	n occurred a vestigation,	in my op	e, date an inion, deal	d place, a th occurre	nd due to the c id at the time, d	ause(s) and late and pla	d manner as st ce, and due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	1/1/1 0-	^		29c.	License	number		2	9d. Date si	gned (Month,	Day, Year)	
	1		/ > /(IVVI IN	(I)			1)3	3/8	4		July	12,20	005	
1	100		30. Name and address of person w	Kushne	-WD	114	Bush	455	Cer	rth	Drive	Reist	estun	MD 2136	
1	Sta Registi	7	31. Date filed (Month, Day, Year)	3 2005	trar's Signa	ture	book	F							

			1 - For State Registrar	State of Maryla		artment of H			ne		
	Physici	an	1. Decedent's Name (First, Middle, Last) Eula Ramona Buttre					2. Date of Death Month	Day 2005	2 Tipe Poeth 7	
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Deal	7.23	
	LAGIIII	61	2205 Amoss Mill Ro	oad		Pyles			Harf	ord	
	Funeral Director		212 28 69/2	7. Age (in y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 19,		thplace (State or Foreign buntry) rginia	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ecation				10d. Inside City Limits	
	Mary f sho	tor	Maryland Harford		Pyle	esville				1 Tes 2X No	
	n the	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	puntry?	
	23a c	alD	2205 Amoss Mill Rd.	•		211	32		USA	-70	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Modicul Evant are must be conflited at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	in 72 hou n "nature Vedicul E	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired,	ation during most of wor	king 16t	. Kind of Business	Industry	
27	giene giene er tha	Com	7	College (1-40) 5+)	Owner	Operator	•		Tavern		
Maryland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last)		Unk	•	18. Mother's Nan Myrtle	ne (First, Middle, Maid Carter	den Sumame)		
	and 2 sho salth and n 27 is mu		19a. Informant's Name/Relationship (Ty) Robbin Lynn Williar	nson (Daught	er) 949	Homberg 1		ral Route Number, Ci altimore, I			
Baltimore,	Pages 1 nent of He ant: If Itar ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	amazzal fram Chata	b. Place of Dispo cemetery, crer olly Hil	natory or other place	dens 7/	3/2005 Ba	Location - City or altimore,		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service License	kouske	B 1	Name and Address ruzdzinsk 407 Old E	s of Facility i Funera astern A	l Home P.A venue Esse	x, Md. 2	1221	
	Physician		23a Pant 1. Enter the disease, or complication, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the die cause on each line.		er the mode of dying		or respiratory arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death) Sequentially list conditions,			15					
8760,	icate be executed physician and s the burial-transit	ical Examiner	If any, leading to inninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
٥.	quires that n signed b uld be deta	þ	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.		_	the cause of death?	
Records,	The law requirate has been sibage 2 should	Completed						24a. Was an autopsy performed	? prior to death?	itopsy findings available completion of cause of	
Vital	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?					th (Check only one)			
on of \	F F F	2	1 ☐ Yes 2 ☒ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	at (? Yes 2 □ No	ome 5 Residence 28d. Describe how in		oify)	
Division of		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, str ecify)		183 2 1110	28f. Location (Street City or Town, St		iral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier 1X Certifying Phys (Check only one) 2 ☐ Medical Examir	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or in-	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
)		Me	29b. Signature and title of certifier	Thend	Par pi	29c. License			Pate signed (Month	h, Day, Year)	
	i.Q		30. Name and address of person who co Martin J. Sheridan	mpleted cause of death (102 Ral+	imore Max	vland 212	227	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Si	gnature	Sperker		mare e p Vial	<u>y 101101 212</u>		

		í	1- State Amend Item 2 Registrer Amend #5, p	23State of Mary erFH.g866.4/	3945/,0707	13769thbHeal	th and M a <i>th</i>	lental Hygie	ne			
	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Z U Veat	2 Time of Death 8		
	/Medic		Virginia 4a. Facility Name (If not institution, giv	Lee e street and number)		Campbell 4b. City, Town, or Loca	ition of Death	Julie 2	22, 2005 4c. County of Death	6:30PM M		
	Examin	er	Morningside Hou			4 4 4	dorf		Charle			
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)		nder 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign		
	Director		577- 02 -2698	OM 2 TF 95	Yrs.	Months Days Ho	ours Min.	Aug. 9,19				
	p .		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	nonting				10d. Inside City Limits		
	shov	5	Maryland Charles	100	. Ony, Town of Et	Waldorf				1 ☐ Yes 2 ☐ No		
	the M	ect	10e. Street and Number			10f. Zip Code		100	Citizen of What Cou			
	23a or	Funeral Director	3628 Bainbridge	Ct.		20603	1	109.	U.S.A	. •		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show apprintly or other traumatic event, the Medical Exacting must be rediffed at ance.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1Yes 2XNo If Yes, GiveYear or Dates:		Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 ☐ No Sp.	ic Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh			
9	2 hou	ted	15. Decedent's E		16a. Dece	dent's Usual Occupation	most of works	161	b. Kind of Business/I	ndustry		
21215-0036	within 7 iene.	Completed	(Specify only highest graves and secondary (0-12) 12th	College (1-4or 5+)	Opera	DO NOT use retired)	most of work		elephone &	Telegraph		
	illed in Hygie other i	BeC	17. Father's Name (First, Middle, Last)	1 - 1		Mother's Name	e (First, Middle, Mai				
<u>lar</u>	ould be to Mental to arked of atic eve	To B	Homer	Hanback			Fan	nie Freez	ze			
Maryland	and 2 should saith and Men T 27 is marke		19a. Informant's Name/Relationship (Kathy Thrift (ng Address (Street and A Bainbridge			,			
Baltimore,	Pages 1 ar nent of Hea int: If Item		20a. Method of Disposition X Burial 2 Cremation 3	Removal from State	-	matory or other place)	June		c. Location - City or 1			
Iţi	artmer artmer ortant injury		* 4 □ Donation 5 □ Other (Special Service Lice			1n Cemetery 2. Name and Address of	2005		Brentwood.			
Ba	permit. Departr Imports any inji		Danis J. A	rand moos	257 6	633 01d Alex	Le xandria	Ferry Ro	l Home, In oad Clinto	n. MD 20735		
	enysician.		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that cause in e	death. Do not en	ter the mode of dying, su	ch as cardiac o	or respiratory arrest	,	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a cor	_					11 - ,		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	pertensi rsequence of):	on				years		
	uted d ansit	min	Cause. Enter Univerlying Cause (Disease or injury that initiated events									
ó	e exectian an	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):							
68760,	icate be executed physician and s the burial-transit	edical Examiner		d								
O. Box	aath certif attending for use a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year		
ds, P	w requires that the debeen signed by the should be detached	by	Part II. Other significant conditions	contributing to death but no	t resulting in the (underlying cause given in	Part I.	23e. Did tobad	cco use contribute to			
lecords,	E S S	Completed						24a. Was an autopsy	prior to c	topsy findings available completion of cause of		
E R	Th ate pag	So						performe 1 ☐ Yes 2/		2 No		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	-	h (Check only one)				
of		. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	nt 3 DOA 4		me 5 Residence 28d. Describe how	e 6 Other (Specinium occurred	cify)		
on	Attending F r death. actor: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	of 28c. Injury at Work? M 1 ☐ Yes			. ,			
Division	or Attendi	Certification:	3 Suicide 6 Could not 4 Homicide determined	De Place of Injury	At home, farm, s pecify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,		
	Hospital of the hours at Funeral Discharation is at the hours at the h	Ce	29a. Certifier 1 Y Certifying P	hysician: To the best of m	v knowledge, dee	th convered at the time, di	ate and place	and due to the equi	co(s) and margar as	etatad		
	To the Hospital or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the	edical		miner: On the basis of exa and manner stated.		nvestigation, in my opinion	n, death occur	red at the time, date	and place, and due	to the cause(s)		
)_	To t To t	Σ	29b. Signature and talle of certifier			29c License nur	nber }	29d	Date signed (Month	n, Day, Year)		
C	(30. Name and a har of person who	completed cause of death	(Item 23a) (Type ld Lige	Centre #100	Waldor	f, Maryla	nd 20602	242-434-		
Í	St Regist	ate	31. Date filed (Month, Day, Year) JUL 1 3 2005	32. Registrar's		Y. 3						
	riegisi	TOI	302 1 0 2000	PRINCIPAL IS	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005 Year **Physician** Huberl enni /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospitai Baltimore Samaritan Good If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 M 2□F Yrs. 1932 Winston-Salem, NS Director 239-46-865 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Baltimore WD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò U.S.A. 21239 items 23e Hillenwood Rd 2033 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if item 27 is marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) 12th Steel worker Bethlehem 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dallie MAE Wesley Cuthrell Williams 2 Hubert 19a. Informant's Name/Relationship (Type, Pri t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Disposition (Name of Date 20c. Location - City or Town, State Cuthrell/wife Ruth other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ö Baltimore, pernit. Page Department of Importent: If any injury or once. Maryland Jul 12,2005 Garden of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ringled a Grayson Fungraj Home 108 W. north ave. Buta. md 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. muld Cirpa Approximate Interval Between Onset and Death nemonea Pnysician ADDINA disease or condition resulting in death) /Medical Due fo (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 X nknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 X No 1 Yes 1 ☐ Yes 2 7 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 After this (funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Vithin 2 29d. Date signed (Month, Day, Year) ,29b. Signature and title of certifier

State

Registrar

31. Date filed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature and the

			For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygiei	2005	22820					
	Physicia	an	1. Decedent's Name (First, Middle, La	EPH CHARLE	C	2. Date of Death	Day Year	3. Time of Death					
>	/Medic Examin	al	4a. Facility Name (If not institution, given		4b. City, Town, or Location of Dea		2005 4c. County of Death						
*	n page		Good Samar		Baltimore								
	Funeral Director			6ex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir		1941 South	nplace (State or Foreign untry) CAKILINA					
	riand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limits					
	Be-f sh	ctor	MD		PACTIMORE			1 V Yes 2 □ No					
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "netural", or Items 23e or 28e-f show or other treumetic event, the Medical Examinar must be notified at	Funeral Director	1314 CRUFFO	N ROAD	10f. Zip Code 212.39	10g.	U.S./						
	er deat	uner	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cyban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	e, etc.					
900	within 72 hours after ene. then "netural", or Ite the Medical Examina	by	3 Widowed 4 Divorced	1 Tyes 2 DNo If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No Specify:		Specify: D	LACK					
21215-0036	in 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b	b. Kind of Business/I						
212	filed with Hygiene. other ther	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	LABORER		STEE	IL .					
land	ould be fii Mental H arked ott	To Be	17. Father's Name (First, Middle, Las	HRLES , SR.		ame (First, Middle, Maid NEVA TH	den Sumame) MAS						
Maryland	2 should and Men Is marke reumetic		19a. Informant's Name/Relationship		b. Mailing Address (Street and Number or F	Rural Route Number, Ci	ity or Town, State, Z						
	of Health of Health litem 27	1	20a. Method of Disposition	20b. Place	of Disposition (Name of ery, crematory or other place)	Date 20c	. Location - City or	Town, State					
Baltimore,	Pa or to		1 Durial 2 Cremation 3 1 1 Donation 5 Other (Special	fy) ST. V	OHN CEMETERY 7.	13.05 BI	SHOPVILLE	, SOUTH CAROLINA					
Bal	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Lice	nsee Sur	22. Name and Address of Facility V	AUCHN C. C. BAITIMORE	GREENE FL T. MARVIA	WERAL HM WD 21212					
			shock, or heart failure. List only	pplications that caused the death. Do one cause on each line.	o not enter the mode of dying, such as cardi			Approximate Interval Between Onset and Death					
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS Due to (or as a consequence	a of):			011001 0110 000111					
ľ	Examiner		Sequentially list conditions,	b. END STAGE RENAL DISEASE Due to for as a consultance off:									
$\sqrt{}$	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consequence									
30,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequence				-					
68760	:= D #	edicai		d									
Вох		Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dear		23d. Date of deli	very Day Year						
P.O.	t the de by the a ached f	hysic	1 Yes 2 No 9 Unknown	4□ Pregnant at time of death 9□ Unknown	5 ☐ Other (specify)								
	The law requires that the death cer tite has been signed by the attendir bage 2 should be detached for use	by P	Part II. Other significant conditions HVPERTENSI	-	23e. Did tobaco		the cause of death?						
cor	s been should	oletec	THERETERS	, , , , , , , , , , , , , , , , , , , ,	Chiles, IIIV	24a. Was an		topsy findings available completion of cause of					
Vital Records,		Comp				autopsy performed 1 ☐ Yes 2 🔀	death?	completion of cause of					
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Impatient 2 ER/C	Other	eath (Check only one)	a [] ()	4.1					
Division of	ng Phy fter this neral d	H- 1	27. Manner of Death 1 Natural 5 Pending		Outpatient 3 DOA Siles 4 Nursing Time of 28c. Injury at Work?	Home 5 Residence 28d. Describe how in		any)					
risio	of or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not	28e. Place of Injury - At home,	M 1 Yes 2 No	28f. Location (Street	t and Number or Ru	ral Route Number,					
Οį	itel or / irs after rel Dire led in b	Certi	4 Homicide	building, etc. (Specify)		City or Town, S.	itate)						
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowled miner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)					
	To the within 24	Me	29b. Signature and title of certifier	1 /	29c. License number		Date signed (Month	/					
	8		30. Name and address of person who	soppleted cause of data (the so	RES 00		7/05						
_	4		JIMMYHENRY MD (Food Samaritan H	Ospital 5601 Loch Ro	ven Blud. 1	Baltimore	MD 21239					
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 3 200	22. Registrar's Signature	Cooli								

Joseph Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 07.11.2005 Physician COFIELD CALPERTA GREEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON GILCHRIST CENTER BALTIMORE HOSPICE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03. 05 - 1955 6. Sex **Funeral** Months 1□M 20 F 50 218.62.9403 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show 1 ☐Yes 2 KNo BALTIMORE Director MD GWYNN OAK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code AVENUE 21207 2125 LORRAINE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK Baltimore, Maryland 21215-0036 Š 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TRANSIT OPERATOR M1A 12/11 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H ANNIE WILSON DOUGLASS L. GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) R. COFIELD 2125 LORRAINE AVE. BALTIMORE, MO 21207 DARRELL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 5 Burial 2 ☐ Cremation 3 ☐ Removal from State 07.16.05 BALTO. MD `4 □ Donation 5 □ Other (Specify) ARBUTUS 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229 23a. Part1. Enter to disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer years Physician Breast /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 월 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) NOS CEE 1 ☐ Yes 2 No Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and file of certifier D58303

State Registrar

ar JUL 1 3 200

31. Date filed (Month, Day, Year)

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32. Region r's Signature

2005

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and address of person who completed cause of death (Item 23a) (Type, Print)

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/Medic	al		STAIN	45 City Town as Location of Donth		10 2005 4c. County of Death	1515
Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	1		-d-1
		Anne Arundel Medi		Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arui	nde L place (State or Fore
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M 2XF 58 Yrs.	Months Days Hours Min.	April 4	Year) Cou	ntry) nany
irector		571-84-2182	38		April 4	,1947 Gell	narry
A ==		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Lim
de de	ō	MD Anne Aru	ndel Odento	n			1 □Yes XX
28a-	Director	10e. Street and Number	inder odeneo	10f. Zip Code	10	g. Citizen of What Cou	intry?
20 20	<u>-</u>			21113		USA	
18 23 0 m	era	597 Chapel Gate D		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri	
id other than "naturel", or itams 23a or 28a-f show event, the Medical Exercite must be notified at	Funeral	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☑ No		o Rican, etc.)	Black, White	, etc.
9.1		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	White
al mark	Completed by	15. Decedent's Edu		edent's Usual Occupation	. 1	6b. Kind of Business/Ir	ndustry
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than the M	E O	Elementary/Secondary (0-12)		ce Manager		Airport	
other ent, I	a	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, M	aiden Sumame)	
C eV	To B	Martin Schalt		Rosa St	toll		
item 27 is markad o othar traumatic eve	-	19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Mai	ling Address (Street and Number or Ru	ıral Route Number,	City or Town, State, Zi	ip Code)
27 is trau		Bobbie J. Chastai		Chapel Gate Drive	e, Odento	n, MD 21113	3
item 27 i othar tra		20a. Method of Disposition	20b. Place of Disc	position (Name of		0c. Location - City or T	
0.0		XXBurial 2 □ Cremation 3 □F	Removal from State	ematory or other place)	3/2005	Crownsville	o MD
rtant		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign it re of Funeral Strvice Licens		Vet. Cem. 7/18	5/2005	CLOMIIZATITE	e, FID
Important: If ite any injury or ot once.		21. Sign fore of Funeral Styles Licens	88	Hardesty Funeral	Home, P.	A.	
		7100	lications that caused the death. Do not en	12 Ridgely Avenue	e, Annapo	lis, MD 214	401 Approximate
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	Maryland	th and Mental to la marked of traumatic even		19a. Informant's Nar		,, ,			19b. Mailir	ng Address (Street and Nur	nber or Rura	al Route Numb	er, City or T	own, State, Zip	Code)
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20	more Pages 1	If Ita		20a. Method of Disper	osition Oremation 3 [Removal from		20b. Plac	e of Dispo etery, crer	sition (Name natory or oth	e of ner place)	1	Date	20c. Loca	tion - City or To	own, State
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 2005 TE /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Baltimore sec ours If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 MM 2 □ F 220-30-719 70 Director 10-2 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or othar traumatic avent. It a Medical Examiner must be recitived at 1 PYes 2 □ No Director tomore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2722 TUR Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1953-1956 Specify: Black 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ustodian tos 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surne Be ပ homas arter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bulto sister Wood 400 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Important: If any injury or Forest 182000 Donation 5 ☐ Other (Specify) rriso. permit. 22. Name and Address of 21. Signature of Funeral Service Licensee Service P.A. 1701 McCulloh lications th 1/2 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Physician onsequence of: /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consquence of: Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 3 Probably 4 Dunknown 1 ☐ Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? this certificate 2□ No 2 0 NO 1 ☐ Yes or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 12 No 1 Inpatient 3100A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Diractor: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 DANG MI. 31. Date filed (Month, Day, Year) HELENA NI.D. 32. Registrar's Signature State Registrar 3 2005

		1- State of Maryland / Department of Heart State of Portificate of Department of Heart Certificate of Department Open Departmen			giene Reg. No 11 11	E 22025
Physic		1. Decedent's Name (First, Middle, Last) Frances C. Christopher		2. Date of Dea Month	ath Day	Year
/Med Exami	ical	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc Crofton Convalescent Center Crofton	ocation of Death	July	4c. County o	005 3:30 A M fDeath Arundel
Funeral Director		214-22-9543 1 M 2 M F 78 Yrs. Months Days F	f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) May 8,	y, Year)	9. Birthplace (State or Foreign Country) Iaryland
death with the Maryland ms 23e or 28a-1 show triust be notified at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Lansdowne				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with the 23e or 28a	Director	10e. Street and Number 10f. Zip Code 221 Second Avenue 21227			10g. Citizen of Wi	•
ē 2 2	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race Black,	American Indian, White, etc. White
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aryland 212 should be filed withind Mental Hygiene. marked other than umetic event, the Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last)	3. Mother's Name Jennie K		Maiden Sumame))
C = 14 F		19a. Informant's Name/Relationship (<i>Type, Print</i>) William H. Christopher — husband 221 Second Aver	nue, Lan	sdowne		
Page ment ant: It ury o		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 1 ◆ □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Cemetery	7/15/2	2005	Mariotts	ity or Town, State
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee . 22. Name and Address of	of Facility Hub	bard Fu	uneral Ho	ome, Inc.
Physician		Immediate Cause (Final disease or condition	such as cardiac or		rest,	Approximate Interval Between Onset and Death
Medical Examine Examine be executed behavioral and the bruil-transit	dicai Examiner	resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):				years
Box 6 death certificate attending pod for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Festal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of Month	
Cords, P.O	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.	23e. Did to	e	ute to the cause of death?
I Rec The law ate has b	Completed			24a. Was a autops perform	sy prid med? dea	re autopsy findings available or to completion of cause of ath?
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Divisit To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, description on the desired form of the property of the prope	date and place, an	nd due to the card at the time, d	ause(s) and mannate and place, and	er as stated. I due to the cause(s)
To ti withi To ti	2	29b. Signature and title of certifier Rakesh anona MD D20	6168	2	9d. Date signed (#	Month, Day, Year) 105
_ 5		Name and address of person who completed cause of death (Item 23a) (Type, Print)	rlesce	ent	Crof	ton, MD
Sta Regist		31. Ďate filed (Month, Day, Year) 33 Registrar's Signature				

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			For State	State of		•	artment rtificate			and M	lental Hy			
			Registrar 1. Decedent's Name (First, Middle, L.	ne#1		Cei	liiicate	OIL	Jeani		2. Date of Dea	Reg. No.	005	272825
	Physicia	an		151)							Month	Day	Year	8:00AM
	/Medic	al .	Jennie E.Carter								July	3,	2005	
	Examin	er	4a. Facility Name (If not institution, gi 103 Sixth Avenue		nber)		_	1 0 wn, or 1 2 2 5	Location of	of Death			ounty of Dea ne Ari	
		in the second			7. Age (In yrs.	last hirthday)	If Under	_	If Under:	24 Hrs.	8. Date of Birt			hplace (State or Foreign
e .	Funeral		214-26-4876	1 M 2 X F	7. Age (in yrs	Yrs.	Months	Days	Hours	Min.	06/05/	928	Mes	t Virginia
h,	Director	1	Usual Residence of Decedent								00,00,	320	WCD	c virginia
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
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	r 282	lrec	10e. Street and Number				10f. Zip						n of What Co	
	th wit	Funeral Director	103 Sixth Avenue				212	225				Unit	ed Sta	ites
	dea ems	ner	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spo	ecify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit	
9	or it	F	1 ☐ Never Married 2 🔀 Married	1 🗀 Yes If Yes, Giv	2 X No	1	1□Yes 2		Specify:		,		pacify: Wh	
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2	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. Id other then "natural", or items 23s or 28s-f show event, the Medical Eram at mitel be troubled.		17. Father's Name (First, Middle, Las			11Ous	SCWIIC	-	18. Mothe	r's Name	(First, Middle,			
an	d be ental cad o	To Be	Dominec Corrall						Maria	a Ro	sa Mura	ture		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23s or 28a-f show any injury or othar traumatic evant, the Medical Erum and must be notified at ones.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	al Route Numbe	r, City or 7	own, State, 2	Zip Code)
	and 2 salth a n 27 ls		Thomas B. Carter	- husba	ınd	103 8	Sixth	Aver	nue, 1	Balt	imore,	Maryl	and 21	225
Baltimore,	of He of He itam		20a. Method of Disposition	70	20b. P	Place of Disponentery, crer	sition (Nam	ne of ther place	θ)		Date	20c. Loca	tion - City or	Town, State
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ati	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Life	ensee .	Λ.	22	2. Name and	d Addres	s of Facilit	y Hub	bard Fu	neral	Home,	Inc.
m	permi Depa Impo any is		I luny 4.	XIN		4	1107 W	/ilke	ens A	venu	e, Balt	imore	, Mary	land 21229
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	/Medical Examiner		resulting in death)		or as a conseq	uence of):						. 820		La Description
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Вох	death certifica e attending ph d for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregna		3					23	d. Date of del	ivery
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7			30. Name and address of person wh	o completed caus	e of death (Item	n 23a) (Type	Print)					. /	J, -J	
	18		CARLOS D. ZIGE	C,M.S	- SUITE	106 . 1	1406 5	CRI	41NH	WY	GLEN	BURK	JIE M	D 21061
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	Sta Registr		31. Date filed (Month, Day, Year)	7 3 200 E	egistra es Signa	ture	Lan	A. B						

amend item// Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CANAVAN CHARLES /Medical 4a. Facility Name (If not institution, give street and number) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 25, 1933 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPITAL CENGER 3x ctions 7. Age (In yrs. last birthday) **Funeral** 6 Sex Birthplace (State or Foreign Country) 1**X** M 2□ F Director 71 MD Usual Residence of Decedent with the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other then "naturel", or Items 23e or 28e-f shov other treumetic event, the Medical Examinations to 1 ☐ Yes 2 ☑ No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11710 Terrytown Road 21136 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 ih and Mental Hygiene. 7 is marked other then "n College (1-4or 5+) Elementary/Secondary (0-12) 12 Firefighter Balt. City Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ellen Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun 11710 Terrytown Road Reisterstown MD 21136
of Disposition (Name of Date 20c. Location - City or Town, State Doris Canavan Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 XBurial 2 Cremation 3 Removal from State `4 ☐Donation 5 ☐ Other (Specify) Garrison Forest Vet Cem 7/15/05 Owings Mills, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility 11824 Reisterstown Road tru Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Causa (Disease or i that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Ves 2 No 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Records, 1 Ves 2 No 3 ☐ Probably 4 ☐ Unknown Comple 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TIBRILLATUON 211 Division of Vital 1 ☐ Yes 20 the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Empatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ No 2 ER/Outpatient 3 DOA this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou... the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORIANDO CONTRAN 32 Registrar's Signature 31. Date filed (Month, Day, Year) 1 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5, 12, 19b per th 9845 7-13-05 vt

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JULY 2005 4:18 P ^M CWEIBER 11 /Medical 4a Facility Name (If not institution give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/15/1932 5. Social Securio Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□ F Months Days Hours Min. Yrs **POLAND** Director 213-25-1683 73 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No PALM BEACH Completed by Funeral Director BOCA RATON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17209 HUNTINGTON PARKWAY 33496 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY LAW traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I ent: If Item 27 Is marked of WOLF **CWEIBER** SONIA EISEN ပ 19b. Mailing Address (Street and Number or RBAA-tril 11011C City or Town, State 1908) 19a. Informant's Name/Relationship (Type, Print) item 27 I 3 CORNELIUS COURT - OWINGS MILLS, MD 21117 BERNICE CWEIBER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ≒ ö Department of Importent: If any injury or once. BETH EL MEMORIAL PARK 07/12/2005 RANDALLSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final gastric Physician Months disease or condition resulting in death) /Medical De to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy performe Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) No Pice 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Natural 5 🗌 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058303 12.2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towsor, m 21204 Cherles, mo 10

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Certificate of Death Reg. No. 2 () 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Parren Clatterbuck , Jr. DC 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Squake Tankin seda tal tomor If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Vest Virginia 7. Age (In yrs. last birthday) Year 8. Date of Birth (Month, Day, Year Oct. 1, 1932 **Funeral** Months Days Hours Min. **X** M 2 □ F 232-48-1277 Yrs 72 Director West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23a or 28e-f show other traumatic event, the Medical Exercit ethors the netliked at 1 ☐ Yes 2/XNo Directo Maryland Baltimore <u>Middle River</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Control Court 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ 💢 🗙 o Korean ð Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It a Market Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Parren Clatterbuck, Sr. Ella Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Clatterbuck (Wife) 15 Control Court, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Gard. July14, 2005 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, p.A 21. Signature of Experal Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immedi ve Cause (Final diseas or condition resultin death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Dubito (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) Box 68760. physician certificate be Physiclan/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40060576

State Registrar

1521

30. Name and Iddress of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Steem & Sparte

9000 Franklin Square Drive

yno completed cause of death (Item 23a) (Type, Print)

rollk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	Maryland		rtment tificate				ental Hy	giene Reg. No. 2	005	0000
	Physici		Decedent's Name (First, Middle, Las Norris	g.		Dew					2. Date of Dea	-	Year 2005	3. Time of Geaul 0
	/Medio Examir		4a. Facility Name (If not institution, give	(1)	oer) ARE		1		Location of	of Death	70-1		ty of Death	
	Funeral Director		5. Social Security Number 6. Security Number 217-05-5600		. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Mar . T	1,7912	Cour	place (State or Foreign otry) yland
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-1 show ont, the Medical Examiner must be notilied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo 10e. Street and Number 4106 Annapolis R			, Town or Lo		Code 212	27			10g. Citizen of		Od. Inside City Limits 1 ☐ Yes 2 ☐ No htry?
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21215-0036	12 should be filed within 72 h and Mental Hygiene. T is marked other than "naf raumatic avent, the Medic	Complete	(Specify only highest grain Elementary/Secondary (0-12) Unknown		for 5+)	life. L	kind of wor OO NOT us Caret	k done a e retired,	<i>uring m</i> osi)	t of workin	ng	Meadow		Cemetery
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68760,	/Medical Examiner bhysician and bhysician and street is the burial-transit	dicai Examiner	23a. Party Enter the disease, or composite the shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Soundfally list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.		PNEUM vence of): (FLL vence of):	MONI	Α			RIGHT			Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2∏Fetal nt at time of de	death 3	Ectopic pre Other (spe						ate of delive	ry Day Year
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Div	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune		4 Homicide determined	/sicien: To the b	f Injury - At hor , etc. (Specify) est of my knov	wledge, death	occurred a	ut the tim	e, date an	d place, as	City or Tow	n, State)	anner as et	I Route Number,
	To the Ho within 24 t To the Ful completely	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	iner: On the bas and manne	is of examinati	ion and/or inv	estigation,	in my op License	inion, deal	h occurre	d at the time, o	date and place, 29d. Date signs	and due to	the cause(s) Day, Year)
4	Sta Registr		30. Name and address of person who of LAKSHMI SAKTHING 31. Date filed (Month, Day, Year)	JELNAT 32. Rec	I+AN gistrar's Signat	900.				TONS	AVE	0		2005 MD-21229

DEW, NORRIS

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200	Funeral Director		5. Social Security Number 429–98–887 Usual Residence of Dec	72	Sex 1XIM 2□ F	7. Age ('In yrs. last bin	Yrs.	Under 1 Year lonths Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 8-1	2–53	Cou	place (State or Foreign ntry) rkansas
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	and 2 sh ealth and n 27 is n	1	19a. Informant's Name/I			Moth			ddress <i>(Street</i> Davis St						032
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Divisi	al or Attendi s after death. Il Director: A d in by the fu	Certification:		Could not be determined	28e. Place	of Injury ng, etc. (\$	- At home, fan Specify)	m, street,				8f. Location (S City or Tow	Street and Nu vn, State)	ımber or Rural	l Route Number,
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			30. Name and address o	person who	completed cause	e of death	h (Item 23a) (1	Type, Print	1 Penn	Stree	et B				
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			1 - For State Registrar	State of Ma	aryland / Depa			Mental Hygie	ene 	22832
	c		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
и	Physici /Medic		Maggie L.	Daniels				Month 07	Day Year 05	10:30 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of Dea	ith
			Holy Cross Hos				r Spring		Montgom	
	Funeral		5. Social Security Number 6. Se	ox 7. Age □M 2ᡚF 9	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(ear) 9. Bir	thplace (State or Foreign ountry)
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	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	or 28)ire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	ath w	ral	410 21st. Street			2000			USA	
	er de	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub.	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 2 1 N If Yes, Give Year or Dates:	10	1 ☐ Yes 🌂 ☐ No	Specify:		Specify: B1	ack
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Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic enone.		19a. Informant's Name/Relationship (7					ural Route Number, C		
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			23a. Party Enter the disease, or comp	lications that caused	the death. Do not ent			Washingto or respiratory arrest		Approximate
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Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)	1		Month Month	Day Year
o.	the c by the achec	hysi	9 Unknown	9□ Unknown						
ر. ح	Attending Physician: The law requires that the de creath. croadh. sctor: The this centificate has been signed by the a py the funeral director, page 2 should be detached to	by P	Part II. Other significant conditions co	entributing to death bu	at not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	w require been sig should b							1 ☐ Yes	2 □ No 3 □ Pr	obably 4 🛮 Unknown
000	e law requ has been je 2 shouk	plet						24a. Was an	24b. Were au	itopsy findings available
Ĕ	The ate his page	Completed						autopsy performed 1 ☐ Yes 2 😾	d? death?	completion of cause of 2 No
Vital	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
	hysic his call dire	ပ	1 ☐ Yes 2X No	Hospital: 1 ☑ Inpatier			4 Nursing H	ome 5 Residenc	e 6 Other (Spec	cify)
Ĕ	ding Phy h. After thii funeral c	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tîme of Injury	Wor		28d. Describe how	injury occurred	
Division of	r Attend er death ractor: / by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	an Bloom (Initial	***		Yes 2 □No	001 1		
<u>></u>	or Dira	artif	4 Homicide determined	building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		City or Town, S	t and Number or Ru itate)	iral Route Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifie 1 Certifying Phy	sician: To the heet of	f my knowledge, death	occurred at the time	ne, date and place	and due to the carro	e(s) and manner	ctated
	e Hos 24 h e Fur etely	Medical	(Chick only 2 Medical Exam	iner: On the basis of and manner sta	examination and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To th within Fo th compi	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Month	h, Day, Year)
			15.54	MIM	•	D-592	84		07-08-05	
i	01/		30. Name and address of person who o	ompleted cause of de	eath (Item 23a) (Type,	Print)				
-	V		Dr. Shahid Sham		500 Forest	: Glen Rd	. Silver	Spring, M	D. 20910	
	Sta		31. Date filed Manth, Day 3 2005	32. Registra	r's Signature	6				
	Registr	ar		1						

			For State Registrar	State of Maryl	•	artment of I		nd Men		ene . No. 200	
	Physicia		Decedent's Name (First, Middle, Last)						Date of Death Jonth	Day Yea	3£Tingé of Death 5
	/Medio Examin		WALTER J. DREGA 4a. Facility Name (If not institution, give st MANOR CARE~ ROSSV			4b. City, Town,		Death	JULY	5 2005 4c. County of Do BALTII	eath
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. D	Date of Birth Month, Day, Y		NORE Birthplace (State or Foreign MARYLAND
	Director		Usual Residence of Decedent	07	Yrs.			Se	pt. 27	,1917	
	Marylar -f ahow	tor	10a. State 10b. County Maryland baltimor		City, Town or Lo	imore cou	∪ntv				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the a or 28a be noti	Funeral Director	10e. Street and Number 310 Dale Avenue			10f. Zip Code	21206		10g	J. Citizen of What	Country?
	ema 23	ıneral		2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cub		in? (Specify Puerto Rica	Yes or No- n, etc.)		merican Indian, hite, etc.
920	ours afte ral', or h Exercin	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No If Yes, Give Year or Dates: W	W11	1 ☐ Yes 2 🔀 No	Specify:			Specify:	White
215-0	within 72 hours after deeth with the Maryland ene. than "natural", or Itema 23a or 28a-f ahow A Medical Exeminer must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire ftsman	pation during most ed)	of working		Sb. Kind of Busine	ss/Industry m Steel Co.
Maryland 21215-0036	Hygir ther ther	Be	12 yrs. 17. Father's Name (First, Middle, Last) Walter G. Drega	2 yrs.	DIG.		1			iden Sumame)	
aryla	2 should be and Mental is marked o	ည	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree					e, Zip Code)
d)	1 and 2 Health a em 27 to ther tra		Gerald J. Drega (S			9 Twin La osition (Name of matory or other pla		rive Jate		sville, Noc. Location - City	1d. 21084 or Town, State
Baltimore,	permit. Pages 'Department of F Important: If Ite any Injury or ot		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)			of Faith		7-9-05	В	altimore	, Md.
Balt	permit. Depart Import any Inl		21. Signature of Funeral Service License	ahn		^{2. Name and Addr Lassahn 1 7401 Bela}	unera.	l Home	imore.	Md. 2123	36
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	death. Do not en	ter the mode of dy	ing, such as	cardiac or res	piratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a cor		E 14E	MILI		FILVE		
L		iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):						
87605TE	ite be executed ysician and ne burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
6876	9 × ite	edicai	d							1	
O. Box	it the death certitics by the attending phached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	су			23d. Date of Month	delivery Day Year
s, P.	uires tha signed d be de	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the t	underlying cause g	iven in Part I.				e to the cause of death? Probably 4 Prophy Probably 4 Prophy Probably 4 Prophy
al Record	The ate h page	autopsy prior to completion of cause performed? death? 1 □ Yes 2 □ No									to completion of cause of
f Vital	Physician: The ribis certiticate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA O	thor		eck only one) 5 □ Residen	ce 6 Other (S	(pecify)
ion of	nding Phith.: After this tuneral		27. Manney of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	W	uryat ork? ⊒Yes 2 ∐1		Describe how	injury occurred	
Division	or Attsndi efter death. Director: A	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	treet, factory, office)		Location (Stre City or Town,		Rural Route Number,
_	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the tune	edical C		ician: To the best of my er: On the basis of exa and manner stated.							
	To the within To the compl	Me	29b. Signature and title of certifier	0			nse number	7.		d. Date signed (Me	
			30. Name and address of person who co	pleted sause of death	(Item 23a) (Type	Print)	0603	00	JI	JLY to	2005 HTIMBE
	0+1	ate	PANKAJ KHETE 31. Date filed (Month, Day, YAR)	PAC 2 O 2032 Registras	01-109 Signature	BACK	KIVE	n NE	ECK P	b., BP	rLTIM HEE
	Regist		JUL 1	3 2005 Registry's S	Signature	Spark					

DHMH 17 Rev 1/2001

			1 - Stete Registrar	State of Maryland /		irtment of		and Me		ene	105	22931
	Physici	an	1. Decedent's Name (First, Middle, Last)	L D 11	_				2. Date of Death Month	Day	Year	3. Time of Death
	/Medic Examin		Helen Elizabet 4a. Facility Name (If not institution, give si			4b. City, Town,	or Location o		uly	7 4c. Coi	2005 unty of Death	10:20 P.M
	Examili	ei	Summerford Assist	74		Co1umb					ward	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Yea Months Days	r If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day,			place (State or Foreign ntry)
	Director		213-12-2028 Usual Residence of Decedent	84	Yrs.				June 23			land
	yland sow		10a. State 10b. County	10c. City, Tov	wn or Lo	cation						10d. Inside City Limits
	e Mar	ctor	Maryland Howard	Col	Lumb	ia						1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	_		10f. Zip Code			10	g. Citizen	of What Cou	ntry?
	eath v	erai	8220 Snowden Ri	ver Pkwy 2. Was Decedent Ever in U.S.	12 1	21045		rin? /Speci	fu Vac ar Na		S.A. Race - Ameri	and to disc
က	or item	by Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Vas Decedent of f Yes, specify Cu		, Puerto Ri	ican, etc.)		Black, White,	
ğ	ours a		3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I⊡Yes 2⊠N	o Specify:			Spe	ecify:	White
5	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Medical Exam me investice routified an	Completed	15. Decedent's Educ (Specify only highest grade	ation 168 completed)	(Give	lent's Usual Occi kind of work don DO NOT use retii	e during most	of working	7	6b. Kind o	of Business/Ir	ndustry
712	s withii iiene. r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		nistrato			1	I.S.	Govern	ment
b	e filed al Hyg i othe vent,	BeC	17. Father's Name (First, Middle, Last)					r's Name (First, Middle, M			
ylaı	ould b Menta arked	Tof	Charles Fullen				Sarah					
Maryland 21215-0036	d 2 sh h and 7 is m treum		19a. Informant's Name/Relationship (Typ	9, Print) 19	b. Mailin	g Address (Stree	et an <i>d Numbe</i> Uni	t 208				
آ. ا	Healt Healt tem 2		Robert C. Donnelly 20a. Method of Disposition	20b. Place	of Dispo	North H sition (Name of		AIA	Indial		on - City or T	
m 0	Pages ent of nt: If i		1 🖾 Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	natory or other pi ark Ceme	.	7-12-	2005			Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23s or 28e-7 show may injury or other treumatic event, the Medical Exquire or intell to multiply at ance.		21. Signature Funeral Service cense		22	Name and Add	ress of Facility	y Homo				
a	20 E 29		Juble C.	Post		itzke Fu 630 Edmo					e, MD	
	Priysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. Last only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do cause on each line.	not ente	er the mode of dy	ying, such as o	ASE	respiratory arre	st,		Approximate Interval Between Onset and Death YEARS
į,	Examiner			Due to (or as a consequence	of):							17
	6	Jer	Sequentially list conditions, if any, leading to immediate cause Enter Underlying	Due to (or as a consequence	of):							
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	cate be executed by sician and the burial-transit	ai E	resulting in additity East	Due to (or as a consequence	e of):							
687	tificate ig phys as the	edicai	d.									
Вох	ndir use	Physician/Me	23b. Was decedent pregnant	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	th 3	lEctopic pregnan				23d.	Date of deliv	ery
	ne death the atte hed for	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of death		Other (specify)					Month	Day Year
P.O.	⇒ > °	Phy	9 ☐ Unknown Part II. Other significant conditions confi	ributing to death but not resulting	in the ur	deriving cause of	aven in Part I		23e Did toba	acco use o	contribute to t	he cause of death?
Division of Vital Records,	The law requires that ite has been signed b page 2 should be deta	d by	NONE			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2 🗆 N		
CO	law requir as been si 2 should I	olete							24a. Was an	24	tb. Were auto	opsy findings available
Ä		Completed							autopsy perform 1 Yes 2	ed?	prior to co death? 1 \(\subseteq \text{Yes}	mpletion of cause of 2 No
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:				of Death	Check onlone			ASSISTED
of	Phys this al diu	1.70	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/O	utpatien Time of	1 JU DON			d. Describe how			y) LIVING
on	nding tth. :: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Injury	W	ork? □Yes 2□N		d. Describe not	v Injury Oc	curred	
Vis	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, stre	et, factory, office	9	28	f. Location (Stre City or Town,	eet and Nu State)	umber or Run	al Route Number,
Ö	Hospitel or Attending 4 hours after death. Funerel Director: After tely filled in by the fune							1				
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examin	cien: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death ind/or inv	occurred at the restigation, in my	time, date and opinion, deat	d place, an th occurred	d due to the car l at the time, da	use(s) and te and plac	manner as s ce, and due t	stated. o the cause(s)
	To the within To the Somple	Me	29b. Signature and title of certifier			29c. Licer	nse number		29	d. Date si	ned (Month,	Day, Year)
			few 1. We	herrem des			0 27	- 394		H	8/200	1
	10		30. Name and address of person who con	npleted cause of death (Item 23a, 700 70, 33, 33, 32. Registress Signature 2005)) (Type,	Print)	17 0	#2	2 - 1.		204	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrate Signature	, ~	. 01000	G Pi	J.	1 1340	-('(/'\(mee .	me 2(218
	Regist		JUL 1	2005 Magain	Jan .	Joseph .	B					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per fth 846 8-12-05 yr State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July**Physician** 12:40 A Daniel Betty Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 15 1 5. Social Security 6788 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 21XF Months 83 502**-1**0-8785 Director ΝĎ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral, or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Parkville MD Baltimore Direct the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 8413 Nunley Drive, Apt. D death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: by White 3 X Widowed 4 □ Divorced Year or Dates 7 is marked other than "netural" treumatic event, I've Medical Ex Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Executive retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Maryland Elementary/Secondary (0-12) <u> Administrative Assistant</u> Casualty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Lewin Olive Mortz Ernest Α. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is eny injury or other tre once. 1001 St. Paul, Apt. 9D, Baltimore, MD 21201 Michael Barrett - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc. 7/12/2005 Beltsville, MD CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Licensee M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lyon phoma years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijur) that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🖄 Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2. No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 A her (Specify) 2 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 - Accident investigation after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗋 Homicide within 24 hours a To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9,2005 D58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MO ZIZOY CHALLES 6601 N. Charles St 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Heren & Specie

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryl	•	artment of H			giene	22026
	Physici /Medic		1. Decedent's Name (First, Middle, Last	ENSOR	SR.			2. Date of Dea Month	ath Day Year 200	5 4:00 AM
	Examin Funeral		4a. Facility Name (If not institution, give 3903 Buckingham F 5. Social Security Number 6. Se	Road 7. Age (in	yrs. last birthday)	If Under 1 Year	imore If Under 24 H	rs. 8 Date of Birti	Baltimo	re inthplace (State or Foreign
	Director		Usual Residence of Decedent	M 2□F 6	7 Yrs.	Months Days	Hours M	in. (Month, Day Oct. 1		
	ne Maryla 8e-f show ctified at	ector	Maryland Baltimor		Baltim	ore		<u></u>		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with to	Dire	10e. Street and Number 3903 Buckingham F	Road		10f. Zip Code	207		10g. Citizen of What C United Sta	
36	thin 72 hours after death with the Maryland e. an "neturel", or Items 23e or 28e-f show Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 195				(Specify Yes or No- erto Rican, etc.)		nerican Indian,
21215-0036	Man and	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of v	working	16b. Kind of Business	s/Industry
	E THE		12	0		Manager	19 Mother's N	lame (First, Middle,	Sanitatio	on
land	be be	To Be		ı Edgar Enso	r			a Lottis (· ·	
Maryland	d 2 should th and Men 7 le marke treumetic	F	19a. Informant's Name/Relationship (7)			ng Address (Street			r, City or Town, State,	Zip Code)
	item 27 I		Mrs. Brenda L. Ens		3903 b. Place of Dispo		am Road	, Baltimon		
nore	Se to T		20a. Method of Disposition 1	Removal from State	cemetery, crer	natory or other plac			20c. Location - City o	
Baltimore,	perrit. Pag Department Importent: I any injury o		21. Signature of Function Service Licens		ian T. Ĉ	hIshoIm I	uneral		of Dulaney	y Valley, P.A 21093
	Physician		23a Phri. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the one caus, on each line.				•		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Brain	nsequence of):	astese	20			2W
8760,	be executed sicien and burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Drease of him) that initiated events resulting in death) Last	c. Due to (or as a cor	modulation of the sequence of	- Cell	Lux	Conce		3M
.O. Box 687	The law requires that the death certificate be executed tte has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ecords, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death but not	t resulting in the u	nderlying cause give	en in Part I.		bacco use contribute fes 2 □ No 3 □ F	to the cause of death? Probably 4 □Unknown
α		Completed						24a. Was a autop perfor 1 🗆 Yes	sy prior to	
Vital	Phyeicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital:	2 ER/Outpatier	other actions		Death (Check only or	ne) ence 6 □Other (Sp	onifu)
ion of	ding After fune	atlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injun Worl			ow injury occurred	Scriyy
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only one) 2 Medical Exam	sician: To the best of my iner: On the basis of exar and manner stated.	knowledge, death mination and/or in	vestigation, in my o	pinion, death o	ccurred at the time, o	date and place, and du	e to the cause(s)
)	Som Som	~	29b. Signature and title of dertifier	usru		24	216 (7	Page Signed (Mon	(In, Day, Year)
10	5		30. Name and address of person who c	nemeleted cause of death	eet T	Salfin	mal	MD 21	201, PET	R HAUNER
İ	Sta Regist		31. Date filed (Month, Day, Year) JUL 1	32. Registra S	Signature .	Sparke)		1	MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 0 0 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Nell Sybil Emory /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner +rAnKlin Baltimore audire HOSPITAL Center If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🖾 F Director 263-30-0494 1925 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, it a Madical Executer must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Highlandtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S. A.

14. Race - American Indian,
Black, White, etc. 504 Fairview Avenue 21224 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3

Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 shoutd be fi h and Mental H 7 is marked ot Othello Dixon Sally Hyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 504 Fairview Avenue Judge O. Emory (Son) Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State any injury or c once. X Burial 2 Cremation 3 Removal from State Oglethorpe Memorial Gardens Saint Simons Island, 4 ☐ Donation 5 ☐ Other (Specify) Georgia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ruzdzinski Funeral Home 1407 Old Eastern Avenue Home PA venue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myo Cardiai /Medical **Examiner** Fibrilla rapid ventricular rate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician the use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) igned by the a be detached f P.O. 9 Unknown Part II. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed pertension, diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has Vital 2 No 1□ Yes 1 TYes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) of death (Item 23a) (Type, Print) Name and address of person who completed o'us

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registras Signature

2005

			1 - For State Registrar	State of Marylar	•		it of Health a e of Death	and Me	ental Hy	/gier Reg. N	0.0	05	22020
	Physici /Medic		1. Decedent's Name (First, Middle, Last ALLEN	ODELL	Fos	TER	?	1	Date of D		2005	Xear	3. Time of Death 0
	Examir		4a. Facility Name (If not institution, give LORIEN FRANK	FORD		4b. City,	Town, of Location of	MORE		4	ic. County of	of Death	
	Funeral Director		5. Social Security Number 6. Se 214-04-3837 Usual Residence of Decedent	X 7. Age (In yrs	last birthday) Yrs.	If Under Months	Days Hours	Min.	B. Date of Bi	irth lay Year	5	9. Birthp	ece (State or Foreign try) CAKOLINA
	Maryland a-f show	tor	10a. State 10b. County	10c. Ci	BACT		ORE					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28i ist be not	al Director	10e. Street and Number 3015 CHESTER	RFIELD AVE		10f. Zip		3		10g. (Citizen of W	S. A	try?
960	be filed within 72 hours after death with the Maryland Ital Hygiene. of other than "naturel", or Items 23a or 28a-1 show event, the Medical Examinar must be notified at	by Funeral	11. Marita Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Deced f Yes, spec 1 ☐ Yes	dent of Hispanic Oric city Cuban, Mexican 2 No Specity:	gin? (Spec i, Puerto Ri	ify Yes or N ican, etc.)	0-	14. Race Black Specify:	, White,	
21215-0036	C 60	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	tent's Usua kind of wo DO NOT us LA	al Occupation rk done during most se retired) BOREK	t of working	,	16b.	Kind of Bus	iness/Ind	2/
Maryland	should be filed within nd Mental Hygiene. I marked other than umatic event, the M	To Be C	17. Father's Name (First, Middle, Last) AUEN M.	FUSTER			18. Mothe	LOT	First, Middle	e, Maide	OAYIS	_	
Baltimore, Mary	ges 1 and 2. I of Health at If item 27 is or other trau		19a. Informant's Name/Relationship (Ty DOR OTHY A FOSTE) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	R (SISTER) 20b. Removal from State	3015 Place of Dispo cemetery, crem	Sition (Name	ne of other place)	D AVE	F. BA	20c.	Location - C	444 City of To	AND 21213
Baltir	permit. Par Department Importent: any injury		21. Signature of Funeral Service Licens		22	. Name an		y VAN	SHN	C.E	KEENE	= FUN	IERAL HOME 21212
8760, <	Physician and ph	dical Examiner	23a. Part1. Enter the disease, or comply shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	idications that caused the deal ne cause on each line. a. END Due to (or as a consect to the c	STA Q quence of): STA quence of):	E	e of dying, such as a A I D_S R FZ				ASE_		Approximate Interval Between Onset and Death 2-3 Y EARS 2-3 Y EARS
.O. Box 68	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of o	el death 3□	Ectopic pr Other (sp					23d. Date Mont		ry Day Year
<u>α</u>	quires that the signed by and be detacted		Part II. Other significent conditions con	ntributing to death but not re	sulting in the ur	nderlying c	ause given in Part I.				use contrib		e cause of death?
Vital Records,		Completed by							24a. Was auto perf 1 Yes		O.e	ere autorior to consath?	sy findings available apletion of cause of
/ita	ysicien: T is certificat director, pa	Be	25. Was case referred to medical examiner?	1 3-1				of Death (Check only	one)			
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Division	al or Attendl after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)			-	f. Location City or To			r or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier Check only one) Certifying Phy	sicien: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred restigation,	at the time, date and, in my opinion, deat	d place, and	d due to the at the time.	cause(s) and man nd place, ar	ner as stand due to	ited. the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier	MY)		Doo 60 ?	378			ate signed		2005
	4		30. Name and address of person who con NIVE DITA BA		m 23a) (Type,	Print) FRA	NIC FORC) A	VEN	RE	_BA	HIGH	nuare MD
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 3 2	32. Registrar's Sign	ature	carle	,						

			4 10	artment of Health and Mertificate of Death		ene LNo2005	22839
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month July 6,	Day OOF Yeer	3. Time of Death
	/Medic		Ples E. Ferguson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 6,	4c. County of Deat	5:30 a M
ı			1146 Sparrow Mill Way	Bel Air		Harfor	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 65 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Y) Dec. 5,	°1939 Te	nplace (State or Foreign untry) nnessee
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e-f sh	ctor	Md. Harford	Bel Air			1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23e or 28e-f show ricust by the filling at	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	ns 23	Funerai	1146 Sparrow Mill Way 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21015 Was Decedent of Hispanic Origin? (Spe	city Yes or No-	U.S.A.	rican Indian.
036	be filed within 72 hours after death with the Marylan Ital Hygiene. Indoorher than "naturel", or Hems 23e or 28e-f show event, Ita Medical Exaction or north to northed at	by Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Widowed 4 □ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	
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andz	e filed Il Hygie other vent, ti	Be Cc	17. Father's Name (First, Middle, Last)	18. Mother's Name			<i>y</i>
yıaı	2 should be and Mental is marked o	To E	James E. Ferguson	Mary E	E. Grubb		
Mar	d 2 sh th and th sm 7 is m treum			ing Address (Street and Number or Rura			
e e	s 1 an if Heal item 2 other		20a. Method of Disposition 20b. Place of Disposition	Sparrow Mill Way, osition (Name of matory or other place)		c. Location - City or	
Saltimor	Page ment o ant: if ury or			ill Mem. Gdns. 7/9/	/2005 M	Middle Riv	er, Md.
Dail	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other treumatic es		telanio Linoley	2. Name and Address of Facility Schimunek Funeral F			
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ter the mode of dying, such as cardiac or My elono	r respiratory arrest		1014 Approximate Interval Between Onset and Death I Geell 4 Mush
	cate be executed physician and the burial-transit	i Examine	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
09/80	licate b physik s the b	edicai	d				
C. Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
ds, r	uires that signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	underfying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
I Records,	The lay te has page 2	Completed			24a. Was an autopsy performed	d? prior to co	opsy findings available ompletion of cause of
VII	ysicien: Is certific director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	(Check only one)		
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VISION	nding Ph ath. r: After th	atlor	1 □Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,	
DIVIS	To the Hospitel or Attending Physicien: which 24 hours after death as a file death To the Funerel Director. After this certifica completely filled in by the funeral director, g	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	ne Hospii n 24 hour ne Funer oletely fille	edica! (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a ovestigation, in my opinion, death occurre	nd due to the caus od at the time, date	se(s) and manner as	stated. to the cause(s)
	To t To t comp	Σ	29b. Signature and title of certifier	29c. License number DI & 487		Date signed (Month)	Day, Year)
	1040		30. Name and address of person who completed cause of death (Item 23a) (Type IN YO TITA NT 602 S. ATW	Print) RUAD, BE	Z AIR,	10 210	14
	Sta Registr	te ar	30. Name, and address of person who completed cause of death (Item 23a) (Type 10 Completed Cause of death (Item	Specific			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LEWIS FIEMING JR. E. JUL 2003 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner CENTER RANDALISSONN BALTIM Pat NAMANESS HUSSITAL If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, NOV 5 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 1**X** M 2□F 214-72-5992 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d, Inside City Limits Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Pikesville Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8208 Streamwood Drive 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Edgar Fleming, Sr. Dorothy Moore permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Baughman/Sister 245 Towyn Court Ambler, PA 19002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 7/12/05 Parkville, MD 21. Signature of Funeral Service Licensee

Fdward A. Cregorchik 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCLERTIL CARDIDYASOULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diato cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the attending physicien and ched for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Ulnknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → nknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Solve Medical Certification: To 1 Inpatient 20 ER/Outpatient 3 DOA harel Director: Atter the filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funarel D 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Day, Year) A PD249 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 21133 540) CLIFFORD FABGE OLD EDVET RUAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Kathleen Elizabeth Gladding Ju₁y 10 2005 2:40P /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons Nursing Home Baltimore Catonsville if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 19 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2ÅF 212-32-0144 90 Director Pennsylvania Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, It a Madical Exeminar must be notified at 1 ☐ Yes 2 🖾 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 S. Hilltop Road 21228 death 1 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Extending Once. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No δ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wagonhafer Mable Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Executor) Bertha Collins 75 Garden Ridge Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-14-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Marriottsville, MD 22. Name and Address of Facility.
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave. Catonsville, Maryland 21228 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 Chemic Physician /Medical Due to (or 's a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. igned by the attending physician be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed' certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥6 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1509 32. Registrar's signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Graham RoseMarie July 7, 2005 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs, last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ₽ F 75 Yrs. Director 217-24-3375 Aug. 26,1929 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits in than "natural", or items 23a or 28a-f show the Modical Examinating the notified at Director 1 ☐ Yes 2 € No Baltimore Dunda1k Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a any injury or other traumatic event, the Mode 21222 Completed by Funeral 7930 Diehlwood Road United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 🐉 No Specify: White Specify: 3x Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Manager Catholic Relief 6 Years Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Carnes 2 Charles J. Isaacson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7930 Diehlwood Road Dundalk, Maryland 21222 Melvin J. Graham, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2x☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/13/2005 Towson, Maryland * 4 ☐ Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailurs. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se Physician Ink /Medical Due to (or as a consequence of); Examiner intra abdomina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Dertorated Due to (or as a consequence of): Box 68760, attending phy... IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by vercel acute tuilure 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No vespiratory has autopsy 2□ No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After ' Certification: Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident **Director**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To use within 24 hours are To the Funeral Dir 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29b. Signature and title 9 29d. Date signed (Month, Day, Year) D24804 07-2005 MD Annopelis completed cause of death (Item 23a) (Type, Print) Pererson 31. Date filed (Month, Day, Year, 32. Registrar's Signature College . Registrar

05-4521 B.K.S CARL GRIFFIN UNK.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

K.()5-4521		1 - For	State of Ma	aryland / Dep			ental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle,	l ast)	Ce	rtificate of D	<i>Jeatn</i>	Re 2. Date of Death	g. No. 200	2291
2	Physic		Carl Griffin						4, Day 2005 Year	2315 P M
9	/Medi Exami		4a. Facility Name (If not institution, UNION MEMORIA)	give street and number) L HOSPITAL		4b. City, Town, or I BALTIMOR	Location of Death E CITY		4c. County of Death	
3.5	Funeral Director		219-80-7209	Sex 7. Ag 1 2 F 7. Ag	e (In yrs. last birthday) 4 4 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2-5-61	Year) 9. Birth Cou	place (State or Foreign intry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show	ţ	MD		Baltimo					Yes 2 No
	ith the Mi or 28a-f	irec	10e. Street and Number		Dareimo	10f. Zip Code		10	g. Citizen of What Cou	intry?
	23a c	a D	2113 E. Chase	st.		21213		τ	ISA	•
036	after or its	by Funeral Director	11. Marital Status 1 ★ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 200 If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☐ No	spanic Origin? (Spe i, Mexican, Puerto F Specify:		14. Race - Amer Black, White Specify:Bla	, etc.
21215-0036	within 9ne. Then	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) College (1-4or 5	+) 16a. Dece (Give life. Libr	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of workin	1	6b. Kind of Business/In	•
	filed Hygin other ent,		17. Father's Name (First, Middle, La	st)	DIDI		18. Mother's Name		alto. Ci	ty
Maryland	Mental Mental arked o	To Be	Unknown			ĺ	Ann S. (
lan,	2 sho and h is ma	1	19a. Informant's Name/Relationship			ng Address (Street an	nd Number or Rural	Route Number,	City or Town, State, Zi,	p Code)
	and ealth m 27		Joyce Montgome	ery (fianc	ee) 2113	E. Chase	e St. Ba	alto. M	D 21213	
lore	ges 1 if ite or ot		20a. Method of Disposition 1 Rurial 2 Cremation 3	☐Removal from State	120b. Place of Dispo	osition (Name of matory or other place)	D	ate 20	c. Location - City or T	own, State
Baltimore,	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		Voshell		7-12-		undalk,	MD
Ba	permit. Departr importe any inje		1 Signature of difference of the second						vis Jr.	
	在		23a. Part1. Enler the disease, a conshock, or heart failure. List on	emplications that caused	the death. Do not ent	er the mode of dying.	ern Ave.	Balto	. MD 212	3 1 Approximate
)	Physician /Medical	2. 3	Immediate Cause (Final disease or condition resulting in death)	_a. Mult	e. ip(Q gu a consequence of):	nshot u				Interval Between Onset and Death
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16	₽ ∺	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	L consaquance of).					
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Records, P.	tw requires that s been signed b should be deta	Ď	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause given	in Part I.		cco use contribute to t	
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Vital	Physician: r this certifica ral director, i	o Be	25. Was case referred to medical examiner? 1. Yes 2 □ No	Hospital:	nt 2 AER/Outpatien		26. Place of Death			
of	ding Phys	\vdash	27. Manner of Death	1 ☐ Inpatier	/ 28b. Time of	28c. Injury a	4 Nursing Hom	e 5 Residence Bd. Describe how	intury occurred	(y)
jo	Attending or death. ector: After by the fune	atio	1 □ Natural 5 □ Pending 2 □ Accident investigat	on (Month, Day	and the same of th		s 2 1 No	4 . 1	was shot	
Division	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			1	28	City of Town,	et and Number or Rura State) 1400 E	Al Roule Number. Leter Hall
	To the Hospital or within 24 hours after to the Funeral Direction completely filled in I	Medicai	29a. Certifier 1 Certifying I (Check only one)	Physician: 10 the best of aminer: On the basis of and manner state	f my knowledge, death examination and/or inv	Occurred at the time	date and place as	d due to the servi	se(s) and manner as s	tated.
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	\cap	İ	30. Name and address of person wh							
	9		LING LI	, m. D	111 PENN	STREET, B	ALTIMORE,	MARYLAN	21201	
-3	Sta Registr	_	31. Date filed (Month, Day, Year)	2005 32. Figistra	r's Signature	barle				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#12.perFH_G845, //13/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 1 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) HURO Month Day Physician AURILE JULY 200 S /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ISALTIMI SUDACUTE NORTHHEST RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**⊠**M 2□ F Days Hours Min. 214-50-353 Director WASH Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Exercitive must be notified at 1 XYes 2 ☐ No Directo BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours atter deeth with Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural". or in-any injury or other treumatic event ŏ ZON CIRCLE AP 46 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 4 es 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify If Yes, Give Year or Dates: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER AREFIRST BLUE CROSS PROGRAMMER YR5 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MAURICE HURD TARCELLA ပ LOWERI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4615 HORIZON CIRCLE APTY, PIKESVILLE, MO. 21208 HURD (WIFE) VENETIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State RRISON FOREST 7-20-05 OWINGS MILLS * 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility BROWN JR, FUNERAL HOME JOSEPH H. BROWN JR, FUNERAL HOME 21217 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINOMA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy 2 No 1 Yes Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) completely within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To. MO NWHC 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State 3 2005 JUL Registrar

			For Stete Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment o	of Health of Dea	n and M th	ental Hyg	iene () (5	22845
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ı	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location	on of Death		4c. County	of Death	
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	Funeral		Social Security Number 6. Security Number	DKU a∏E	(In yrs. last birthda)	/) If Under 1 \ Months D	Year If Und	der 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign htry) laryland
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	and	}	10a. State 10b. County		10c. City, Town or I	Location				-		10d, Inside City Limits
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p	be file	Be (17. Father's Name (First, Middle, Last)				18. Mo	other's Name	(First, Middle, I	Maiden Sumam	Θ)	
<u>yla</u>	should tind Meni	ဥ	William		Hyson		Ja	ine			Bend	lemeyer
Maryland 21215-0036	2 sho and ls m		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mai	ling Address (S	treet and Nu	mber or Rura	l Route Number	, City or Town,	State, Zip	Code)
	1 and 2 Health tem 27		Tammy A. Harrison	(Daughter							_	ınd 20732
altimore,	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cr	oosition (Name ematory or othe	of r place)	D	ate	20c. Location -	City or To	own, State
Ξ	Pag ment ent: ury		`4 □Donation 5 □Other (Specify		Glen Ha	ven Mem	ı. Pk.	7/14/	/05	Glen Bu	ırnie	, Maryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f ehow eny injury or other treumatic event, the Madical Exercitive must be published at once.		21. Signature of Funeral Service Licen	isee		22. Name and A McC11111v	Address of Fa	niak Fı	meral H	Iome. P	Α.	
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Division of Vital Records,	Attending Physicien: r death. ector: After this certifics by the funeral director, I	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	М	Work?	.□No				
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	ospite hours uneral ly filled		29a. Certifier 1 Certifying Ph	ysicien: To the best of	f my knowledge, dea	ath occurred at t	he time, date	and place, a	and due to the ca	use(s) and ma	nner as s	tated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical	one)	niner: On the basis of a	ed.							
	To the within 3	≱/	29b. Signature and title of certifier		_	29c. L	icense numb		2	9d. Date signed	(Month,	Day, Year)
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18			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	e, Print)						
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ORIGINAL

		For State Registrar	State of Maryland		tificate			III CA IVA		eg. No	0	
Physic /Med		1. Decedent's Name (First, Middle, Last) LLOYD B.	HORTON, JR.						2. Date of Deat Month JULY 11	2005	U.5	7 Time Poleath
Exami		4a. Facility Name (If not institution, give a 230 Old Magot	street and number) hy Bridge Road	d		Town, or saden	Location o	f Death			y of Death Arund	el Co.
Funeral Director		013 22 0313	7. Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth Aug. 11	1929	9. Birth Cou Mas	place (State or Foreigntry)
Maryland s-f show	tor	Usual Residence of Decedent 10a. State Md. Anne Aru		, Town or Lo sadena								10d. Inside City Limit
h with the	ai Direc	10e. Street and Number 230 Old Magothy	Bridge Road		10f. Zip	Code 2112	22		1	0g. Citizen of U.S		ntry?
ges 1 end 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If Rem 27 is marked other than "naturel", or Rems 23a or 28e-f show or other treumatic event, the Medical Examina must be multipled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Deced f Yes, spec 1 ☐ Yes	offy Cuba	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	Bta	ce-Ameri ick, White, hite	can Indian, etc.
filed within 72 ho Hygiene. other than "natur ant, the Medical	Completed	15. Decedent's Edu (Specify only highest grade			dent's Usua kind of wor DO NOT us femp	rk done d se retired,	luring most)	of workin	ng .	Machi		dustry
ould be filed Mental Hygie arked other atic event, to	To Be C	17. Father's Name (First, Middle, Last) Lloyd Baker	Horton					rs Name nifre	(First, Middle, Med		Spend	llove
end 2 should balth and Men n 27 is marke		19a. Informant's Name/Relationship (Ty Carol V. Horton	ре, Print) (Wife)	19b. Mailir 230	ng Address Old M	(Street a	nd Number	r or Rura Cidge	Route Number	City or Town Pasade	na, N	Id. 21122
permit. Pages 1 end 2 Department of Health a Iraportent: If Item 27 Is any injury or other tre once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F ↑ 4 □ Donation 5 □ Other (Specify)	C6	ace of Dispo metery, crer dowrid	natory or o	ther place	ial Pl			20c. Location	•	
permit. Page Department Irriportent: If any injury or once.		21. Signature of Funeral Service License	otap.	22	MC (3204	ully Hou	7-Poly intair	niak n Roa	Funera ad, Pasa	l Home	P.A.	21122
Physician /Medical Examiner and physician and the burial-transit		shock, of heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). EALLU Due to (or as a consequence).	ence of): RE ence of):	10N TC) 7	[1+1	212	NOM	A		Interval Between Onset and Death
death certifi e attending id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic production of the second seco			_		1	ate of delive	ery Day Year
requires that the veen signed by th hould be detache	d by Pł	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the u	ndertying ca	ause give	en in Part I.		23e. Did tot			he cause of death?
The law te has b	Completed								24a. Was a autops perform	y /	Were auto prior to co death? 1 Yes	opsy findings availabl impletion of cause of
Physicien: Th this certificate ral director, pag) Be	25. Was case referred to medical examiner?	Hospital:			Othe	\r		(Check only on			
fe fe	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 28b. Time of Injury		8c. Injury Work	4 🔲 1401	- 8	8d. Describe ho	nce 6 ⊡Oti w injury occu	. ,	(y)
To the Hospital or Attendi Within 24 hours after death. To the Funerel Director: A completely filled in by the t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, str)	eet, factory	, office	3.20	2	8f. Location (St City or Town		ber or Rura	al Route Number,
Hospi 24 hour Funer tely fill	Medical	29a. Certifier (Check only open 2 Medicel Exemi	sician: To the best of my knowner: On the basis of examinat	vledge, death ion and/or in	occurred vestigation,	at the tim in my op	ie, date and pinion, deat	d place, a h occurre	and due to the ca	ause(s) and mate and place,	anner as s and due t	tated. o the cause(s)
To the Within : To the comple	Med	29b. Signature and tipe of certifier	and manner stated.		290	. License	number		2	9d. Date signe	ed (Month,	Day, Year)
H	1	30. Name and address of person, who co	mpleted cause of death (Item	51(1) 23a) (Type.	Print))4:	204)		7/12/	0.2	
//		21/15 Ritches	Highway I	30001	dim	PI	Inla	MI	1.212	25		

			1 - For State of Maryland / Dep	artment of F ertificate of			Re	g. No. 2	105	2201 =
	Physici	an	Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day 08	Year	3 Time of The sta
	/Medic	al	Mavis Henderson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	at agation of	Dooth	07	4c. County	05	9:45P M
	Examin	er	Heartland Sligo Creek		a Park			· · · · · ·	tgome	rv
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	tf Under 1 Year	If Under 24	4 Hrs. 8	Date of Birth	1		place (State or Foreign
	Director		577-72-2444 1□M 2점F 72 Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, 10 15	32	Guya	
	pu >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	oastion						Od Inside City Limits
	shov	or	MD Montgomery Takoma							0d. Inside City Limits tx□ Yes 2 □ No
	28a-f	ect	10e. Street and Number	10f. Zip Code			10	g. Citizen of	What Cour	
	with 3a or	Ī	7620 Maple Avenue #624	20912				USA		,
	death ms 2	Jera		Was Decedent of H	Hispanic Origin	in? (Specif	fy Yes or No-	14. Rad	e - Americ	
9	or ite	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 ₺ No If Yes, Give	1 ☐ Yes 2 🖾 No		Puerto Hi	can, etc.)		ck, White, v: B1a	_
21215-0036	ural',	d b	3-∆ Widowed 4 Divorced Year or Dates:							
<u>-</u> 2	"net	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occup e <i>kind of work don</i> e DO NOT use retire	pation during most o	of working	1	6b. Kind of B	usiness/In	dustry
7	within ene. than	omo	Elementary/Secondary (0-12) College (1-4or 5+)	terer	<i>a</i>)			Self H	Emp1o	ved
D D	Hygother other	e C	17. Father's Name (First, Middle, Last)		18. Mother's	's Name (F	First, Middle, M			
<u>lar</u>	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "netural", or Items 23s or 28s-f show atto event, the Medical Examer must be notified at	To Be	Charles Haywood		Emu]	letta	Bakker	•		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or items 23s or 28a-4 show early injury or other treumatic event, It is Medical Examination at Once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street	and Number	or Rural P	Route Number,	City or Town,	State, Zip	Code)
	and lealth m 27 her tr			Maple Av	ve. #62	24 Ta	koma PA			
or S	ges 1 It of H If Ite or ot			ematory or other pla				Oc. Location	1	
Baltimore,	it. Pa rtmer rtent njury			Vashingtor 22. Name and Addre		7-18-		Adelphi		
Ba	Depar Import eny ir		De Marshall	217 9th.	St. N.	.W. W	hall's ashingt	on, D.		
U			23a. Part 5 hten he disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.	nter the mode of dyin	ng, such as ca	ardiac or n	espiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Mydel	nje	ull	lle			Criset and Death
E	/Medical Examiner		Due to (or as a consequence of):	At t	7 ()					
		er	Sequentially list conditions, if any, leading to immediate b. Sub to (or as a confeq en 1).							
	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):							
8760,	ate be hysici the bu	licai	d							
9	ertifica ling ph	Physician/Med	IF FEMALE:					1		
Вох	eath certific attending p I for use as I	ian	In the past 12 months?	□Ectopic pregnancy	у				te of delive onth	ory Day Year
o.	the de	iysic	1 Yes 2 No 4 Figural at lifte of death 5 9 Unknown 9 Unknown	□ Other (specify) _						
Д.	res that the de signed by the a be detached f	by Pł	Part II. Other significant conditions entributing to death by no presulting in the	underlying cause giv	ven in Part I. S	`	23e. Did toba	acco use conf	ribute to th	ne cause of death?
Records,	w require: been sig should be	ed b	Mela state holar	Uno Oll	conon	2	1 ☐ Yes	2 □ No	3 🗌 Prob	ably 4 Illaknown
900	e law re has bee ye 2 sho	piet		0			24a. Was an autopsy		Were auto	psy findings available impletion of cause of
		Completed					perform	ed?	death?	2 No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to med examiner?			of Death (C	Che ck only one)		
of	Physi this c	7°	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA			5 Residen			1)
no	ding P. After funera	tion	1 🛣 Natural 5 🗆 Pending (Month, Day Year) Injury	Wor	rk?]Yes 2.∐No		d. Describe hov	v injury occur	190	
Division	Attending Physician: r death. sctor: After this certific: by the funeral director.	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s						er or Rura	l Route Number,
5	s after el Dire	Certi	4 ☐ Homicide determined building, etc. (Specify)				City or Town,	State)		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) X Certifying Physicien: To the best of my knowledge, deal on the basis of examination and/or and manner stated.	th occurred at the time timestigation, in my o	me, date and opinion, death	place, and occurred	d due to the cau at the time, dat	use(s) and mate and place,	anner as st and due to	ated. the cause(s)
	withii To the comp	M	29b. Signature and title of certifier	29c. Licens	se sumber	7	29	d. Date signe	d (Month,	Day, Year)
1	12/			15	019			//_	14/	\sigma^{\cdot}
(\supset		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Nasreen Kango, MD. 7600 Carroll		Takoma	PArl	. Md. 1	2091	V	
	Sta	te			Lanoma	TILL	-9 1144 2			
	Registi		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Caroline 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Randallstown Northwest Center BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛱 F Yrs. Director 214.24.1937 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 Is marked other then "naturel", or Items 23e or 28a-f show treumstic event, the Medical Examinating the notified at 1 Yes 2 No Director NA BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2816 EDGECOMB CIRCLE SOUTH 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN BALTO CITY SCHOOLS 121H GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE HARDY MAMIE WAT8ON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) 6703 FOX MEADOW RD. Health item 27 I CATHERINE L. KEA BALTO. MD 21207 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State jo : 0 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. DRUID RIDGE 07.13.2005 PIKESVILLE ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MO 21229 23a. Part1. En whe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Intrinsic /Medical Due to (or as a consequence Examiner hyperlension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physiclan/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Type II diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an page 2 s autopsy performed? Yes 2 No A Hypothyroidism arteri disease 1∐ Yes 1 Yes 2 No oronary Division of Vital or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 1 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident he hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 8, 2005 D28462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, Maryland 21133 Center Northwest Boston MD Hospital

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State

Registrar

31. Date filed (Month, Day, Year)

3

2005

32. Registrar's Signature

			For State Registrar		State of M		d / Depa	artmer	nt of H	lealth and	-		2000	22	91.0
	Physici	an	1. Decedent's Name			Harma					2. Date of Do Month		y Year	3. Time of	
	/Medic	al	4a. Facility Name (If r	James				Ab City	Tour	Location of Deat	July	5	2005 County of Death	1:50	a ^M
	Examin	er							_	_	n	40.	_		
	Funeral		5. Social Security Nur	o Vista		je (In yrs.	last birthday)	If Unde	rnole r 1 Year	If Under 24 Hrs		rth ,	Anne Ar	place (State	or Foreign
L	Director		228-07-8	859	X M 2□F	87	Yrs.	Months	Days	Hours Min.	Oct. 2	ay, Year) 20 ,]	Cot	ginia	
	and ***		Usuel Residence of D 10a. State	ecedent 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside C	ity Limits
	Maryl f sho	ō	MD	Anne Aru	ınde1		Arnold							1 🗆 Yes	-
	r 28a	Director	10e. Street and Numb						p Code			10g. Cit	tizen of What Cou		
	th with	a D	850 Mago	Vista F	Road			2	21012				USA		
	ems	ıner	11. Marital Status		12. Was Decedent Armed Forces		S. 13.	Was Dece	dent of H	ispanic Origin? (S In, Mexican, Puer	Specify Yes or Note Rican, etc.)	0-	14. Race - Amer Black, White		
36	J within 72 hours after death with the Maryland jiene. is then "natural", or Items 23e or 28e-f show the Macilcal Examination notified at the Macilcal Examination or or or or or or or or or or or or or	by Funeral	1 Never Married 3 Widowed 4		1 XYes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:			Specify:	White	
21215-0036	2 hou	ed		5. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occup	ation		16b. K	ind of Business/I	ndustry	
215	within 72 ene. then "nal	pie	(Specify Elementary/Second	only highest gradary (0-12)	de completed) College (1-4or	5+)	(Give lite.	DO NOT u	ork done d use retired	during most of wo f)	rking				
7	filed wit Hygien other the	Completed			2		NSA					1	. Govern	ment	
nd	be da la be	Be	17. Father's Name (F							18. Mother's Na			,		
yla	Mer	P		nklin Ha			405 Mail		- (Caa		ginia H			(- O- 4-)	
Maryland	7 Is		Janice H	Harman (V			P			and Number or Re a Road,				р Соав)	
	s 1 and 2 of Health Item 27 I		20a. Method of Dispo	sition		20b. P	lace of Dispo emetery, crei				Date		ocation - City or 1	own, State	
Baltimore,	Page ent c nt: If ry or		1 2 8urial 2 □ 1 4 □ Donation 5		Removal from State		ryland			1	-2005	Cro	wnsville	MD	
ati	artra		21. Signature of Fund	eral Service Licen	S00					ss of Facility Funeral				,	
8	Dep Imp gng		175-	7.4						Ly Avenu			MD 21	401	
			23a. Part1. Enter the shock, or heart	disease, or comp failure. List only	olications that cause one cause on each I	d the death ine.	n. Do not en			0		arrest,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (F disease or condition resulting in death)	inal	a	P	ark.	s Jor	2	11 se	150			44.	15
	/Medical Examiner		, southing in additing		Due to (or as	a conseq	uence of):							/	
		Je.	Sequentially list cond if any, leading to immo cause. Enter Under	ditions, nediate	b. Due to (or as	a conseq	uence of):								
V	cuted nd ransit	Examiner	that initiated events	ijury	c										
, 00	death certificate be executed eattending physicien and of for use as the burial-transit	EX	resulting in death) La	ist	Due to (or as	a conseq	uence of):								
68760,	physic physic the b	dicai			d										
9 X	eath certific attending p	Physician/Med	IF FEMALE:		23c. If yes, outcome	of progna	incy						23d. Date of deliv	(80)	
Вох	d for L	ciar	23b. Was decedent in the past 12 π 1 ☐ Yes 2 ☐	nonths?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	□Ectopic p □ Other (s _f					Month	*	Year
P.O.	at the de by the a	hysi	9 Unknown	140	9 Unknown										
S, F	The law requires that the ste has been signed by th bage 2 should be detache	by P	Part II. Other signific	1	1 01			inderlying (cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of o	death?
ord	v require been si should t	ted	1/2	he may	-s U.S	eysy	ల				1 🗆	Yes 2	No 3□Pro	bably 4 □	Jnknown
Record	e law r has be je 2 sh	Completed									24a. Was	psy		opsy findings omptetion of o	available ause of
E H		Con									1 ☐ Yes	ormed?	death? 1 ☐ Yes	2□ No	
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referre examiner?		Hospital:				Oth Oth	00	ath (Check only				
of	Phys r this ral di	1: To	1 ☐ Yes 27. Manner of Death	10	1 🗆 Inpati		ER/Outpatier 28b. Time o		UA	4 Nursing r	10me 5 Res		6 □Other (Spec	ify)	
OU	ding f th. : After s funer	tion	1 XNatural 2 ☐ Accident	5 Pending investigation	28a. Date of Inj (Month, Da	ay Year)	Injury	М	28c. Injun Worl	k? Yes 2∐No			,		
Division	I or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of the	jury - At ho	ome, farm, st	reet, factor	ry, office		28f. Location City or To		nd Number or Rui	al Route Num	iber,
Ö	rs after or rel Dir				Danosig, o							,, oldic			
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edicai	29a. Certifier (Check only	Certifying Ph	ysicien: To the best niner: On the basis	of examina	wledge, deat tion and/or in	th occurred ivestigation	at the tin	ne, date and place pinion, death occi	e, and due to the urred at the time	cause(s , date an) and manner as d place, and due	stated. to the cause(s	5)
	thin 2 the omplei	Med	one) 29b. Signature and to	tle of certifier	and manner s	tated.	-//	29	c. Licens	e number		29d. Da	te signed (Month	Day, Year)	
	⊬ ≱ ⊬ ŏ		•	- 2	7	7/	n		Do	205549	5			7.00	7
	1		30. Name and addre	ss of person who	completed cause of	death (Iten	п 23а) (Туре,	Print)				<	ر ازادو	1	<u> </u>
_	5		MARK D.	PHILLIPS		700	Best	ate	, Ke	2) Ste	303 K	map	polis 1	10 21	401
	St. Regist	ate rar	31. Date filed (Month	n, Day, Year)	32. Regist	rar's Signa	iture J			,		/			

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		for State		•		d / Dep	artment o	of Health	and M	ental Hygi	iene			
		Registrar					rtificate	or Death	7		ig. No? []	15	228	50
Physic	ian	Decedent's Name (First, Min Edward		ahaal		Hecen			İ	2. Date of Death Month	Day	Year	3. Time of	Jeath
/Med	ical			chae1		Hogan				July 8		15	2315	М
Exami	ner	4a. Facility Name (If not institu	-					wn, or Location	n of Death		4c. County			
		Anne Arundel 5. Social Security Number	Medi 6. Sex			last birthday		polis	er 24 Hrs.	8. Date of Birth	Anne			. F
Funeral Director		213-36-9777		M 2□F	64 (111 yrs.		Months D		Min.	(Month, Day,	Year)		place (State or ntry)	Foreign
		Usual Residence of Decedent				•				Jan. 25,	1941	Mar	yland	
/land		10a. State 10b. Cour	nty		10c. Cit	y, Town or L	ocation						10d. Inside Cit	y Limits
Man,	ţ	MD Ann	e Aru	nde1		Annapo.	lis						1 🗌 Yes	2XNo
r 286	Director	10e. Street and Number					10f. Zip Co	ode		10	og. Citizen of V	Vhat Cou	ntry?	
Ind 21215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. Id other than "natural", or items 23a or 28e-f show event, the Madical Evantrer must be recitied at		404 Holly D	rive				2	1403			US	A		
deat	Funeral	11. Marital Status	1	2. Was Decede Amed Force	nt Ever in U	.S. 13.	Was Deceden	t of Hispanic C	rigin? (Spe	cify Yes or No- Rican, etc.)			can Indian,	
after or Ite	F	1 ☐ Never Married 2 😿 M		1 Ves 2[If Yes, Give			1 ☐ Yes 2 🗓			iloan, oto.)		k, White,		
ours earl	dby	3 Widowed 4 Divord	ed	Year or Date	s:						Specify	/: 	White	
72 h	Completed	15. Deced (Specify only hig	ent's Educ he <i>st gr</i> a <i>d</i> e			16a. Dece (Give	dent's Usual C kind of work of DO NOT use r	occupation done during mo	ost of working	ng 1	16b. Kind of B	usiness/fr	ndustry	
	m m	Elementary/Secondary (0-12	2)	College (1-4d	or 5+)									
dygied in	ပိ	12 17. Father's Name (First, Midd	(o l ast)			Sup	ervisor		hade Nama	(First, Middle, M	Constru		<u>n</u>	
and it be for the formal Helphology	Be									C. Hart		(0)		
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Madical Event	ျင	Edward F. Ho 19a. Informant's Name/Relation		n Print)		10h Maili	na Address /C					Ctoto 7	- Codel	
Man d2s than 7 ls r	1					1	1			Route Number,		State, Zij	o Code)	
Healt Healt Healt Healt Healt Healt		Susan A. Hog 20a. Method of Disposition	an (w	iie)	20b. F					olis MD	21403 20c. Location -	City or T	own State	
Pages nent of the sant: If its ury or o		1 🗆 Burial 2 🔀 Crematic		moval from Sta	re		osition (Name of matory or other							
Itin It. Part Itant Injury		* 4 □ Donation 5 □ Other			Met		ematory		7/11/		altimo	re,	MD	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Medical Examinat must be notified at once.	ļ	21. Signature of Funeral Servi	CO LINGISO			2	Hardes	ty Fun	eral 1	Home, P.	Α.			
		23a. Part1. Enter the disease	or dodalio	ations that caus	ad the deat	h Do not on				, Annapo		D 21		
		shock, or heart failure. L	ist only on	e cause on each	iline.	n. Do not en	ter trie mod o	1			51,		Approximate Interval Betw Onset and D	eath
Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	_ a.	_		116	2001	C	m C	Fr				
Examiner		, rooming in county		Due to (or	as a conseq	uence of):								
	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b.	Due to /or	as a conseq	uence off:								
Je is	nin	Cause (Disease or injury	<	200 10 (01	us u conseq	461106 01).								
60, be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to (or	as a conseq	uence of):						-		
8760, icate be execute physician and s the burial-transi	calE		١.											
D × 0			a.											
Box 68 eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outcor							23d. Dat	e of deliv	erv	
Box leath cert attendin for use	ciar	in the past 12 months?		1□Live birth 4□Pregnant			□Ectopic pregr □ Other (specif				Mo		-	ear
the dy ached	ysl	9 Unknown		9□ Unknowr	1			,,						
det t	by Pl	Part II. Other significant cond	litions cont	ributing to deatl	but not res	ulting in the u	inderlying caus	se given in Pari	t I.	23e. Did tob	acco use cont	ribute to t	he cause of de	ath?
rds luires										1 ☐ Ye	s 2 🗆 No	3 🗆 Prol	oably 4 🕼	nknown
Records, the law requires t the has been signe age 2 should be	Completed							-		24a. Was an	24b. 1	Nere auto	ppsy findings a	vailable
The lay ate has page 2	E E									autopsy	ned2	orior to co death?	impletion of ca	
Vital F siclan: Th certificate irector, pag		25. Was case referred to med	ical					26 Pla	on of Dooth	1 Yes 2 (Check only one		Yes	2∐ No	
f Vita ysiclan: is certific director,	o Be	examiner?		ospital:	atient 2	EB/Outnatie	nt 3 DOA			ne 5 Reside	-	or /Speci	6.1	
on of ding Phys After this funeral di	I	27. Man r of Death		28a. Date of I	njury	28b. Time o		Injury at		28d. Describe ho			y)	_
on on ording Fig. 1. After a funera	tio	1 VNatural 5 ☐ Per 2 ☐ Accident inve	ding stigation	(Month,	Day Year)	Injury	М	Work? 1 ☐ Yes 2 [□No					
Division or Attending after death. Director: Afte	ifica	3 ☐ Suicide 6 ☐ Cou	ld not be emined	28e. Place of	Injury - At h	ome, farm, st	reet, factory, of	ffice	2	8f. Location (Str		er or Run	al Route Numb	er,
Div	Certification;	4 _ Homicide		building,	etc. (Specif	у)				City or Town	, State)			
Hospital 24 hours Funeral stely filled		29a. Certifier 1 Certif	ying Phys	cian: To the be	st of my kno	wiedge, deal	h occurred at t	he time, date a	and place, a	ind due to the ca	use(s) and ma	nner as s	tated.	
Division of Vita vithe Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	(Check only 2 Medic	ai Examin	er: On the basis and manner	s of examina	tion and/or in	vestigation, in	my opinion, de	eath occurre	ed at the time, da	ite and place,	and due t	o the cause(s)	
To the within 2. To the complet	ž	29b. Signature and title of cert	ifier / A.	1			29c. L	icense number	12/	29	d. Date signe	Month.	Day, Year)	
		N. M	1 W	W/ /	20			1984	70		7/9/	120	J	
k		30. Name and address of pers	on who cor	npleted cause of	f death (Item	23a) (Type,	Print) /	1 2	1	1	1	1	0.0	
10		I To	VEIT	17/61/	7 6	001	510/11	NIF	16	1 41)	11471	100 1	100	
	ate	31. Date filed (Month, Day, Ye			strar's Signa	ture	aste)			7	1	1		
Regis	trar	JUL 1	3 200	5 Been	Jan S	5 19		/						

			Tor State Registrar	State of Ma	ryland	•	artment of F		ind Me			2005	22	0 = 1
			Decedent's Name (First, Middle, Last)						2	. Date of Dea	th		3. Time of I	Death
Н	Physici /Medio		Virginia Yvonne H	oward						Month 07	08	Year 2005	9:20 7	Δм ^м
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o	f Death	<u> </u>		ounty of Death		N-1
			12713 Lee Ben Ro				Kingsvi	ille	2411			Baltimo		
П	Funeral Director		5. Social Security Number 6. Set	7. Age]M 2 <mark>X</mark> F	65 (In yrs. 12	ast birthday) Yrs.	Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day 3/08/1	Year)		place (State or ntry)	Foreign
			220-36-0604 Usual Residence of Decedent		0.5					3/00/1	940	Virc	inia	
	rylane thow	L	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City	-
	8a-f s	cto	MD Baltimo	re	Ki	ingsvi							1 🗆 Yes	2 X No
	with the	Dire	10e. Street and Number				10f. Zip Code			1	10g. Citize	n of What Cou	ntry?	
	s 234	erai	12713 Lee Ben Ro	ad 12. Was Decedent E	ver in 11	3 13	21087		nin? (Specif	fy Vac or No-		S.A. Race - Amer	can Indian	
,	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗶 N			Was Decedent of H If Yes, specify Cuba		, Puerto Rio	can, etc.)	'	Black, White		
93	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2XINo	Specify:			S	pecify: Wh:	ite	
21215-0036	be filed within 72 hours efter death with the Maryland that Hygiene. Id other than "natural, or items 23a or 28a-f show other than "natural, or items 23a or 28a-f show event, the Medical Evertifier must be netified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad			16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most	of working		16b. Kind	of Business/fr	ndustry	
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)			d)				-		
2	e filed v Il Hygie other t		10 17. Father's Name (First, Middle, Last)			Hom	emaker	18. Mothe	r's Name (i	First, Middle.		Home		
au	should be nd Mental marked o	To Be	William Albert G	rubb				Fee	io Th	elma S	hol+	သက		
Maryland	shou ind M mar	-	19a. Informant's Name/Relationship (T)			19b. Maili	ng Address (Street						p Code)	
	permit. Pages 1 and 2 should be Department of Heelth and Menta Important; if item 27 is marked any injury or other traumatic ev once.		Walter E. Howar	d (husband	d)	127	13 Lee Be	en Roa	d - K	ingsvi	lle,	Maryla	nd 210	087
Baltimore,	of He of Herr		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	,	20b. PI	ace of Dispo	esition (Name of matory or other place	-	Dat			ation - City or T		
Ĕ	Peg ment ant: i		'4 □Donation 5 □Other (Specify)		Hol	lly Hi	ll Mem. C	3dns	07/11	/2005_	Balt:	imore,	Marylar	nd
3alt	Depart Depart Import any inj pnce.		21. Signature of Funeral Service Licens	88		2:	2. Name and Addre	ss of Facility	у Е. F	. Lass	ahn 1	Funeral	Home,	P.A.
	0.D = 6 O		Jes. A. Jay	schn	M		1750 Bela					, Maryl	and 21	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	Θ.						rest,		Interval Betw Onset and D	veen
	Pnysician /Medical		disease or condition resulting in death)	a			Luter	·/ C) (((0315			Jeni	A.
ŀ	Examiner	П		, , ,		. 1100 017.								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequ	ience of):								
>	acuted ind transl	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequ	ience of):								
87	physics the k	edicai		d			-					1		
Box 6	eath certific attending p I for use as i	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23	d. Date of deliv	/Arv	
	death e atte	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant at			Dectopic pregnancy Other (specify)	У				Month	•	ear
P.0	that the de ned by the a detached t	hys	9 □ Unknown	9∐ Unknown										
	9 P	by P	Part II. Other significant conditions co	ntributing to death bu	ut not resu	ulting in the u	inderlying cause giv	ven in Part I.				e contribute to		
ord	w requir been si should	ted								1 🗆 Y	es 2	No 3 ☐ Pro	bably 4 □U	nknown
Vital Records,	e law hes b	Completed								24a. Was a autop	sy	prior to c	opsy findings a ompletion of ca	
alF										perfor	2 X No	death?	2 🗆 No	
Vita	Physician: Tribis certificerral director, p	o Be	25. Was case referred to medical examiner?	Hospital:			Ott	200		Check only o				
ot		 -	1 ☐ Yes 25€ No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatie 28b. Time o	IL 3 DOA	4 □ Nu	rsing Home	d. Describe h		Other (Spec	ify)	
lon	nding P tth. :: After I e funera	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		rk?]Yes 2.∏!	No					
Division	ial or Attendli s efter death. al Director: Al ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju-	ury - At ho	me, farm, st	reet, factory, office		28	f. Location (S City or Tow		Number or Ru	ral Route Numb	oer,
Ö	ital or rs effe ral Div	Cer		building, oto		7			W					
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	edical	(Check only 24 Medical Eyami	sician: To the best of iner: On the basis of and manner sta	avaminat	ion and/or is	wooting in my	anining don	th coourres	lat tha tima	data and a	Jaco and due	to the equipolat	
	To the within To the comple	Me	29b. Signature and title of certifier	A A	-		29c. Licens	se number			29d. Date	signed (Month	, Day, Year)	
	*		> All Huth.	my /the	iy.	(111)	02	500	Ś		Ju	(-, S.	2005	
	H		30. Name and address of person who c	and manner sta	eath (Item	23a) (Type	Print) 701 M.	Chorl	e, St.	Galt	, MA	d 21	204	
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	(parts)							
E	Regist	rar	JUL 1 3	ZUUD JUZZ	Charles of	September 1								

			Please			indelible ink				
			1 - For State Registrar	State of Ma		epartment of F Certificate of		entai ⊓ygi Re	g. N2 0 0 5	22852
	Physici	on.	1. Decedent's Name (First, Middle, La					2. Date of Death Month		3. Time of Death
	/Media	cal	Pauline M. Hilgart					July 1	2 2005	2:30A.M.
	Examir	ier	4a. Facility Name (If not institution, giv Baltimore Washingt		Center	Glen Bu	or Location of Death	(Anne Arun	
	Funeral		5. Social Security Number 6. S		(In yrs. last birth	day) If Under 1 Year		B. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director	ļ	212-01-1403 Usual Residence of Decedent	_ W 231	85 Y	rs.	8	Sept 11	, 1919 Mary	yland
	iryland show	_	10a. State 10b. County		10c. City, Town					10d. Inside City Limits
	the Ma	ecto	Maryland Anne Art	undel	Ein	Phicum 10f. Zip Code		10	g. Citizen of What Co	1 Tes 2 No
1	h with	Funeral Director	308 Jerlyn Avenue				21090		nited Stat	
7	ar deat	uner	11. Marital Status	12. Was Decedent E Armed Forces?			Hispanic Origin? (Speci an, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Ame Black, White	
JARTINES	within 72 hours after death with the Maryland with 72 hours after death with the Maryland one. than "natural", or Itams 23a or 28a-f show it Madical Examinational be rediffed at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 😿 N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
25	72 hou	Completed	15. Decedent's E (Specify only highest gra	ducation de completed)	6	Decedent's Usual Occup Give kind of work done	during most of working	, 1	6b. Kind of Business/	ndustry
25	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ife. DO NOT use retire nk Manager	d)		Finance	
11/2 July	al Hygi	Be Co	17. Father's Name (First, Middle, Last,			in ranager	18. Mother's Name (faiden Sumame)	
7	y ould b	70	Walter Schroeder				Mary Stri			
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	iges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Menial Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic evant, the Medical Examination in a cellinatian.		19a. Informant's Name/Relationship (Patricia Lynn Gitt			Mailing Address <i>(Street</i> 3 Jerlyn A v				
Ţ	es 1 al of Hea of itam r othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		20b. Place of D	Disposition (Name of crematory or other plan	Ce) Dat	te 2	Oc. Location - City or	Town, State
PHULINE HIGHETNI	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than any injury or other traumatic evant, ILLA MODE.		' 4 □ Donation 5 ☑ Other (Specil	entombment	Loudon	Park Maus.	7/15/	Programme and the second	altimore,	
	Depa Impo any ii		21. Signature of Puneral Service Lich	2in			ess of Facility Hubb ens Avenue,		-	
	36	Г	23a. Part1. Enter the disease, or don shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	t enter the mode of dyir	ng, such as cardiac or r	respiratory arre	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a URIN	Dry T	RACI 10	MEGIO	V		Onset and Death
	Examiner		f f	Due to (or as a	TEXTU):				
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):				
۷	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):				
0228	ate be ex hysician the burial	cal	(d			<u> </u>			
9,4	feath certificate b attending physic	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy			<u> </u>	Old Date of dali	
	death death ad for u	Physiclan/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 ☐Live birth : 4 ☐ Pregnant at	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of deliment	Day Year
	that the died by the detached	Phys	9 ☐ Unknown Part II. Other significant conditions of	9□ Unknown	ot and an existing in the		To Book	OG Did tob		
Od skynood letty to noisivio	uires tha	by	Partil. Other significant conditions t	ontributing to death bu	it not resulting in t	ne underlying cause giv	ren in Part I.	1 \(\text{Yes}	acco use contribute to s 2 No 3 ☐ Pro	bably 4 Unknown
Ş	ne law requir has been si ge 2 should	Completed					-	24a. Was an		opsy findings available ompletion of cause of
à	The cate ha	Com						autopsy perform 1 Yes 2	ed? death?	2□ No
Viit	ysician: Th	o Be	25. Was case referred to medical examiner?	Hospital: Inpatier	nt 2□ER/Outo	atient 3□ DOA Oth	26. Place of Death		nce 6 □Other (Spec	w.,
ý	ding Phys	-	27. Mar er of Death Natural 5 □ Pending	28a. Date of Injur (Month, Day		ne of 28c. Injur			w injury occurred	ny)
	or Attanding later death. Diractor: After in by the funer	icatle	ccident investigation	1			Yes 2□No	f Looption (Str	eet and Number or Ru	m I Courte Alumbas
	al or Attances after death	Certification:	4 Homicide determined	building, etc	. (Specify)	i, street, lactory, office	201	City or Town,		ai noute ivuilibei,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be deteched for use as the burial-transit	Medical (29a. Certifier (Check only one) Certifying Pt	ysician: To the best on niner: On the basis of and manner state	examination and/	death occurred at the tir or investigation, in my o	me, date and place, and opinion, death occurred	d due to the cau at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To tha within 2 To the complete	Me	29b. Signature and title of certifier		1	29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
			Frita	A	W	DY	3977	F	my 12	2005
	5		30. Name and addless of person who	completed cause of de	eath (Item 28a) (T	Print) Print)	In Bm	ne m	45! 210h	1.
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Spinature	H. Boss	W		1 - 10	
	Regist	ar	50		Jan Saller	- 1				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	•	Certificate of Death	Reg. No. 2005 22052
Dhusisian	Decedent's Name (First, Middle, Lest)		te of Deeth Service of Deeth Onthy Day Year
Physician /Medical		Ji	Ly 9 2005 /0:15M
Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location	
	MANORCARE DULANEY TOW		BALTO.
Funeral Director	3. Social Security Number 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. lest 79	birthday) If Under 1 Year If Under 24 Hrs. 8. Day Hours Min.	te of Birth opth, Day, Year) 9. Birthplace (State or Foreign Country) Uest Virginia
Du s	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, To	own or Location	10d. Inside City Limits
larylar show ed at			1 ☐ Yes 2√☐ No
the M 28a-f potts	Maryland Baltimore Phos	10f. Zip Code	10g. Citizen of What Country?
th with the Maryle 23e or 28e-f sho at be notified at	2/2 Gramerica Project	21131	LISA
eeth w matt	24 Surnyview Drive 11. Meritel Status 12. Wes Decedent Ever in U.S.		
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. 7 is marked other than "retural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	3 □XWidowed 4 □ Divorced Year or Detes:	 13. Was Decedent of Hispenic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican, 1□ Yes 2♥No Specify: 	Black, White, etc. Specify: White
Ind 21215-002 De filed within 72 hours lall Hygigene. John than "Instural", vont, the Medical Exa Be Completed by	15. Decedent's Education 16 (Specify only highest grede completed)	Sa. Decedent's Usual Occupetion (Give kind of work done during most of working	16b. Kind of Business/Industry
21.	Elementery/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
Marie 1	В	Home Maker	Oun Hame
De Hilliam	17. Fether's Name (First, Middle, Last)		Middle, Maiden Sumame)
aryla should b and Ment to market urmatic		Cynthia Cla	aire Wilson
Lar and aum		9b. Mailing Address (Street and Number or Rurel Route	
and 2 saith an n 27 la		4 Sunnyview Drive Phoenix, Mar	
O - 7 5 5	20a. Method of Disposition 20b. Place 20b. Place ceme 20b. Place	of Disposition (Name of tery, crematory or other place)	20c. Location - City or Town, State
Peges nant of Innt: If the Iny or o		y Valley Mem. Gardens 7/14/0	15 Timonium, Maryland
Balti parmit. Depertin Importa any Inje	21. Signature of Funeral Service/Licenses	22. Name and Address of Fecility	1050 York Road
Bampaman Bampan Bany Bany Bany Bany Bany Bany Bany Ba		Ruck Towson Funeral Home, Ir	rc. Tausan.Md. 21204
	23a. Pert1. Enter the disease of control of the shock, or heart failure. List may be cause on each line.		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or es	Stare Renal (): a consequence of: any tract into	S.Oaf Q. Onset and Death
	_ Urin	and Tract out.	OCTION.
I Records, P.O. Box 68760, The law requires that the death certificate be asscuted see has been signed by the attending physicien and page 2 should be datached for use as the burial-transif Completed by Physician/Medical Examiner	Sequentially list conditions, Due to (or es	e consequenca of):	
a a a a a a a a a a a a a a a a a a a	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		1
68760, ificate ba as physicien as the buria	thet initieted events resulting in death) Lest Due to (or as a	e consequence of):	
K 66			Į.
daath ce e attendi			
P.O. BOX 6 that the death certific ed by the attending p detached for use es	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	3b. Did tobacco use contribute to the cause of death?
P.C.	Domeno	76	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Bo) or Attending Physician: The law requires that the death ce fact death of the the this certificate has been signed by the attend in by the funeral director, page 2 should be detected for us ertification: To Be Completed by Physician.	Dement Hyperton		
cord v require been sig	HYPERTON	15.M	ta. Was an autopsy performed? 24b. Were autopsy findings available prior to
Reccession in the second secon			completion of cause of death?
The International Page Age and			1 Yes 2 1 No 1 Yes 2 1 No
f Vital Response to the land of the land o	25. Was case referred to medical	26. Plece of Deeth (Chec	ck only one)
ratch s cer direc	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residenca 6 ☐ Other (Specify)
vision of Vita Attending Physician: r death: r death: r death	27. Menner of Death 28e. Dete of Injury 28b.		escribe how injury occurred
ior ath. e fur e fur	1 ⊠ Neturel 5 □ Pending (Month, Dey Year) 2 □ Accident investigation	M 1 Yes 2 No	
Attended by the	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, building, etc. (Specify)	farm, street, factory, office 28f. Lo	cation (Street and Number or Rural Route Number, by or Town, Stete)
District of in Oct.	Building, etc. (Specify)		y 0. 10W/I, 5.000/
Division of V To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completaly filled in by the funeral dire Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled control on the basis of examination end menner steted.	ge, death occurred et the time, date end place, and durend/or investigation, in my opinion, death occurred et the	
Within ompound	29b. Signature and title of cartifier	29c. License number	29d. Date signed (Month, Day, Year)
	Y Naym Attending P.	11/51chen 05366	2 July 11 +005
107	30. Name end address of person who completed cause of deeth (Item 23e) 31. Dete filed (Month, Day, Yeer) 32. Registrer's signature	MRassiBlue 30.	3 Baltimne 21239
State	31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature	parti	(0//
Registrar	THE 1 S YOU'S LIKE		

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	arylan		artment of H		nd M		giene Neg. No. 🤈 () 0 ~	
	Physici		Decedent's Name (First, Middle, Last	JAMES E	STE	E JOH	NSON			2. Date of Dea Month		Year	3. Zime of Seath L 8:30 PM M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	R CAR	E	4b. City, Town, or			MORE	4c. County		
	Funeral Director		213-60-6272	x 7. Ag	e (In yrs. I 49	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day Oct 2	, _{Year)} , 1955	9. Birthi Coul	place (State or Foreign ntry) MD
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD.		10c. City	, Town or Lo	cation					,	10d. Inside City Limits 1 Yes 2 No
	3a or 28a	i Director	10e. Street and Number 2011 N. WOLFE STREE	T			10f. Zip Code	21211	13		10g. Citizen of \	What Coul	
36	rs after deatl I', or Items 2	by Funerai	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕱 If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cubar	spanic Origin, Mexican, Specify:	in? (Spe Puerto	cify Yes or No- Rican, etc.)	14. Rad Blac Specify	ck, White,	can Indian, etc. Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show princip or other traumatic event, I're Medical Exacting must be notified at ance.	Completed	15. Decedent's Ed (Specify only highest grad	ucation	5+)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired, MACHINE	luring most ()			16b. Kind of B		dustry
land 2	uld be filed v Aental Hygie rked other i tic event, II	To Be Co	12 17. Father's Name (First, Middle, Last) HULIN J	OHNSON						(First, Middle,	Maiden Suman		
	alth and Men 27 Is marke 127 Is marke		19a. Informant's Name/Relationship (T				g Address (Street a						Code)
altimore,	Pages 1 and 2 nent of Health ent: If item 27 I ury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify)		20b. P	emetery, cren	sition (Name of natory or other place HELL CEMET			07/09/05	20c. Location -	-	own, State RE, MD
Balt	permit. Departr Importe eny inje		21. Signature of Funeral Service Licens Leoffry	Mille	moor	14 22	Name and Addres. Miller"s I 1639 No	Metropo	litan (Chapel P.C Baltimore	, Maryland	121213	3
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or comp shock, or heart failures. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	a consequ	JA 9	er the mode of dying		ardiac o	r respiratory ari	est,		Approximate Interval Between Onset and Death
8760, <		dicai Examiner	Causs (Diseass or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):							
.O. Box 6	ath certifi ittending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Da Mo	te of delive	ery Day Year
<u>α</u>	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions co	entributing to death b	ut not resu	ulting in the ur	nderlying cause give	n in Part I.					he cause of death?
Il Records,		Completed							_	24a. Was a autop perfor	med?	Were auto prior to co death? I Yes	opsy findings available mpletion of cause of
on of Vital	Phyeicien: r this certifica ral director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Malnpatie 28a. Date of Inju (Month, Da	iry	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at 4 V urs	sing Hor	(Check only or ne 5 ☐ Resid 28d. Describe h	ence 6 Oth		у)
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, str	eet, factory, office		-	28f. Location (S City or Tow		er or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funerel I completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best iner: On the basis o and manner st	f examinat	tion and/or inv	restigation, in my op	inion, death	occurre	ed at the time, o	late and place,	and due to	the cause(s)
).	To t withi To tl	M	29b. Signature and trie of certifier	Attend	ing	Physic	29c. License 29c. License 29c. License 29c. License	number 364	Z	2	July	7, Z	Day, Year)
	7		30. Name and address of person who d	5	601	23a) (Type,	Print	Bh	d	BAH	more	21	239
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 3 2	32. R sistr	ar's Signa	ture	ask						

			1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of	Marylan		artmen rtificate			and M	lental Hy	Reg. No:		5	2 Prince Dants
ı	Physici /Medic	al	Milton Ray John 4a. Facility Name (If not institution, giv	son	nor!		4h City	Town or	Location	of Death	Month June	22, 2	2005 County of	ear Death	5:08 P M
	Examin	er	University of Ma					timo		Deau		40.	County of	Dealli	
	Funeral		5. Social Security Number 6. S	Sex 7		last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	9	. Birthp	lace (State or Foreign
	Director		220 00 1734	10XM 2□F		34 Yrs.	Months	Days	Tiodis	191111.	(Month, D. 3 – 1 1	771	M	ID	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City Limits
	Mary I-f sh	tor	MD Baltimo	ore	Ro	sedal	e, MI	D							Yes 2□No
	or 288	lrec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wha	at Cour	itry?
	23a c	ralD	6630 Ridgeborne	e Dr.			212	237				USA			
38	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Expropriet must be multified at	by Funeral Director	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or Ne Rican, etc.)		14. Race - Black, ' Specify:	White,	etc.
Maryland 21215-0036	72 hor	Completed	15. Decedent's E (Specify only highest gra				dent's Usua kind of wor			t of work	na	16b. Ki	nd of Busir	ness/Ind	dustry
21	ithin 7	nple	Elementary/Secondary (0-12)	Coilege (1-4	lor 5+)	life.	DO NOT us	e retired,)	l or work	ng .	_			
22	filed w Hygier other th		10th 17. Father's Name (First, Middle, Last	1		Coo	K		18 Mothe	r'e Name	(First, Middle		t Fo	od	
and	d be fantal head of	Be C	Milton Johnson								Price		Sumame)		
ar Z	2 should be and Mental Is marked o	Ը	19a. Informant's Name/Relationship (19b. Maili	ng Address	(Street a			I Route Numb		r Town, Sta	ate, Zip	Code)
Š	and 2 salth a n 27 ls		Linda Johnson			4112	Dud	ley	Ave.	Ва	lto.	Md 2	1213		
Baltimore,	es 1 a of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐	Domouni from St	20b. F	Place of Dispo	sition (Nam	ne of ther place	9)	C	ate	20c. Lo	cation - Cit	ty or To	wn, State
Ĕ	Pages ment of ant: If it ury or o		'4 □ Donation 5 □ Other (Special			yview	Cren	nato	ry	7-5	-05		dalk		
3a	permit. Pages 1 a Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Lice	nsee	1						ley C				
	707 # 0		23a. Part1. Enter the disease, or com	, fres	no.						. Bal			212	3 I Approximate
	/Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	aDue to (o.	r as a conseq	juence of	lVi€	25							Interval Between Onset and Death
O. Box 68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d23c. If yes, outco	h 2∏Feta nt at time of c	ancy	Ectopic pro						23d. Date o		ry Day Year
<u>a</u> .	that the	Phy	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying ca	ause give	en in Part I.		23e, Did	tobacco u	se contribu	ute to th	e cause of death?
rds,	w requires that been signed should be det										10	Yes 2[XN0 31	☐ Prob	abiy 4 Unknown
Division of Vital Records,		Completed									24a. Was auto perf 1 X es		prio dea	r to cor th?	psy findings available impletion of cause of
Ž	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	. P.		(Check only				
ō	Phys r this ral di	T. To	1X Yes 2 No 27. Manner of Death	. 1 🗆 Ini		ER/Outpatier 28b. Time o		A	4 🗀 140		me 5 Res 28d. Describe		·····		/)
O	nding th. : Afte	tlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of (Month)	Day Year)	Injury 1:51	A_M	Bc. Injury Work	:? ∕es 2. X (i		501	160+	- 059		11 fed
Divisi	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place o	f Injury - At h	ome, farm, st				`	City or To	wn. State	d Number	or Rura	I Route Number,
	Hospita 24 hours Funeral stely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example (Check only one)	n ysician : To the b miner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date an sinion, dea	d place, th occurr	and due to the ed at the time	cause(s) , date and	and manne place, and	er as st	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and marine	- oracou.			License		-		29d. Dat	e signed (f	Month.	Day, Year)
1	->-0		> Carol	talla	LU 11	ud		OCME				Juno	23,	200	15
	3		30. Name and address of person who	AULT	to u	id	Print)	Pen	n Str	eet	Balti				nd 21201
	Sta Regist		31. Date filed (Month, Day, Year)		gistrar's Signa	yure for	whi								

		1 - For Amend Item#17, Registrer	State of Maryl 19a, per F	and / Depa H G846	artment of H	ealth and l Death	Mental Hy	giene Reg. No.		
Physi /Med		1. Decedent's Name (First, Middle, Last Merlin Eugene d	Jackson				2. Date of De Month July		2005	3. Figure of Death 8: 408 546
Exam	al	4a. Facility Name (II not institution, give Gilcrest Nursil 5. Social Security Number 6. Se	ng	yrs. last birthday)	4b. City, Town, or If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	Ba	ounty of Death 1 timor 9. Birthol - Count	e ace (State or Foreign try)
death with the Maryland ms 23a or 28a-f ehow control to notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number	10c.	79 Yrs. City, Town or Lo	10f. Zip Code		1-31-	26	IN	0d. Inside City Limits 1 ☑Yes 2 ☐ No
OU36 hours after tural, or ite	eted by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grac	12. Was Decedent Ever i Armed Forces? 1 (2) Yes 2 (1) No If Yes, Give Year or Dates:	16a, Dece	21215 Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 No dent's Usual Occup- kind of work done of	Specify:	pecify Yes or No o Rican, etc.)	16b. Kind	Black, White, especify: Black	ck
be file ttal Hyg of othe	To Be Completed	Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last) Merlin E. Jacke	John Merli	Driv	n		ne (First, Middle,		sporta	tion
e, Mar) 1 and 2 sho Health and 1 em 27 is me	ī	19a. Informant's Name/Relationship (T) Yvette Thomas 20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 II 4 Donation 5 Other (Specify	Removal from State	5812 b. Place of Dispo cemetery, crer	ng Address (Street of Jonqui sition (Name of natory or other place) The Fores	and Number or Ru l Ave.	ıral Route Numbe	Bal 20c. Loca	to. MD	21 21 5 wn, State
Baltimor permit. Pages Department of Important: If it any injury or o	OUCe.	21. Signature of Faneral Servine Licens 23a. Part1. Enter the disease or compshock, or heart failure. List only of	har &	22 20	Name and Address	ern Ave	esley C e. Balt	havi	s Jr. ID 2123	FH
cate be executed Examination and physician and physician ithe burial-transit	al	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conduction of the conduction		igher	ght Le	g ·u(md	ise as	14	gent years
Geath certifi e attending	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Uriknown	Fetal death 3	Ectopic pregnancy Other (specify)			23	d. Date of deliver Month	y Day Year
Hecords, P.O. The law requires that the ten been signed by the bage 2 should be detached.	b	Part II. Other significant conditions of	olon com		memin	en in Part I.	10	Yes 2	No 3 ☐ Proba	e cause of death?
(0 1	Be Completed	25. Was case referred to medical	ewse, Hy	perte	noion	26. Place of Dea	24a. Was autor perfo	rmed? 2 No	24b. Were autop prior to com death? 1 ☐ Yes	sy findings available apletion of cause of
g Phy g Phy er this	2	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Injun Worl	er: 4 □ Nursing F	lome 5 ☐ Resident 28d. Describe t	dence 6)	Other (Specify,	Horrice
DIVISION 16 Hospitel or Attending 124 hours after death. 16 Funerel Director: Afte	Certification;	3 Suicide 6 Could not be determined	building, etc. (Sp	pecify)			City or Tov	vn, State)	Number or Rural	
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier 1AT Certifying Phy (Check only 2 ☐ Medicel Examone) 29b. Signature and title of certifier	vsician: To the best of my iner: On the basis of exar and manner stated.	mination and/or in	vestigation, in my o	pinion, death occu	irred at the time,	date and p	lace, and due to signed (Month, D	the cause(s)
IVA -		30. Name and address of person who of	oppleted cause of peath	(Item 23a) (Type,	Print) Cha	105 des 64	Balto	soly.	2/2	05
Regi	State strar	31. Date filed (Month, Day, Year)	32. Figistrar's S		and a		,,,-0,,			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year 1545 **Physician** harles IUL /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MUTICALE BACTI MORR NA KPSWICK If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Davs Hours Md. Director 2-27-26 216-20-3888 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health end Mental Hygiene. Itam 27 is marked other than "natural", or items 23e or 28s-f show other traumstic event, the Modical Exarcher must be notified at 1 X Yes 2 No Funeral Director Baltimore NA Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 2441 Guilford Ave. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. Gair Operator 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Deller Iona Kess Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) f of Health 2441 Guilford Ave., Baltimore, Md. Wife Priscilla E. Kess 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Popnation 5 ☐ Other (Specify) Garrison Forest Vet. Cem.7-14-05 Owings Mills, Md. 21. Sinature of Funeral Service Lie 22. Name and Address of Facility Baltimore, Md. 1101 E. North Ave. 21202 March F.H. East at1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line? Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician le mediate Cause (Final dise use or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 □ Probably 4 □ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 24/10 1 ☐ Yes 2 ☐ No ti Wes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of De th 28c. 28d. Describe how injury occurred

eral Director: After this certificate hes been signed by the ettending physician end filled in by the funeral director, page 2 should be deteched for use es the buriel-transit Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Certification: To To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: A

Pages 1 and 2 should be filed within 72 hours efter death

Baltimore, Maryland 21215-0020

1 Aaturel 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Check only one)

28a. Date of Injury (Month, Dey Year) 28b. Time of

Injury a Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and eddress of person who completed cause of death (Item 23a) (Type, Print) tAren N-

onson.

State Registrar

completely

edicai

ž

31. Date filed (Month, Day, Year)

29a. Certifier

32. Register's Signature

			1- For State of Maryland /		rtment of H		nd Mental	Hygiene Reg. Ne		22250
			Decedent's Name (First, Middle, Last)					of Death	2003	3. Time of Relate
	Physici /Medic		Betty Jane Knecht				UMont	V /1	2003	5 4:55 AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of	Death	40	. County of Deat	h
		•	Levindale Health Care 5. Social Security Number 6. Sex 7. Age (In yrs. last b	(د د استان داد	Balt If Under 1 Year	imore	Hrs C. D.	- (B: 45		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs.	Months Days		Min. (Mon	of Birth th, Day, Year) 13,19	9. Bin	hplace (State or Foreign junitry) yland
	9		Usual Residence of Decedent				000.	13,19	29 Mai	yland
	how	_	10a. State 10b. County 10c. City, Tov	wn or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	Maryland Baltimore		Baltimor	e				1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number		10f. Zip Code			10g. Ci	tizen of What Co	untry?
	s 23g	erai	11 Marital Status 12. Was Decedent Ever in U.S.	12.1	212		-2 (Ct- V		.S.A.	desa Indian
10	d within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23a or 28a-f show the Micical Examiner must be motified at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ Narried	13. 4	Vas Decedent of H f Yes, specify Cuba	an, Mexican, F	Puerto Rican, et	C.)	Black, White	
936	urs al		3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	I□Yes 2⊠ No	Specify:			Specify:	hite
21215-0036	72 ho	Completed by	15. Decedent's Education 16a (Specify only highest grade completed)		lent's Usual Occupa		of working	16b. K	(ind of Business/	Industry
2	S . C .	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	1)	, working			
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Maryland	9 to 2 to 2	o Be	Arthur L. Adams, Sr.				Taylor	iodie, ivialdel	r Sumame)	
<u></u>	E B G &	ř		b. Mailin	g Address (Street			lumber, City	or Town, State, 2	Zip Code)
	nd 2 lith a 27 Is		Daniel S. Knecht, Sr. (Husband) 1	123	Elm Road	Ra1t	imore.	Marvla	nd 2122	7
Baltimore,	ss 1 an of Heal Item 2		20a. Method of Disposition 20b. Place of compete	of Dispos	sition (Name of natory or other place		Date		ocation - City or	
Ē	nit. Pages partment of the cortant: If Ite injury or of injury or of e.		X Burial 2 Cremation 3 Hemoval from State		Forest		-14-200	5 Owi	ngs Mill	s, Maryland
alt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee	22	Name and Addres	ss of Facility	lome of			-
ш	70 F 9 9		Malel By and						le, Mar	Inc. vland 21228
ш			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dyin	g, such as ca	irdiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	gon	athy					Grisot and Death
	/Medical Examiner		Due to (or as a consequence	e of):	0					
1		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e of):	2.746					
V	uted d ansit	Examiner	Cause, Enter Underlying Cause (Useass or injury							
0,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence	∌ of):						
8760,	ate Pe	icai	d							
9	ertifica ling ph e as t	Physician/Medi	IF FEMALE:							
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat		Ectopic pregnancy				23d. Date of deli Month	very Day Year
oʻ.	at the de by the a stached	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5	Other (specify)					
Q	res that t igned by be detar		Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause give	en in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
ds	luires n sign ald be	d by						1 🗋 Yes 2	□No 3□Pr	obably 4 nknown
00	s been si s should I	iete					24a.	Wasan	24b. Were au	topsy findings available
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ita		O	25. Was case referred to medical			26. Place of	f Death (Check		10 165	2010
	d is	To B	examiner? 1 Yes 2 No Hospital: Ampatient 2 ER/O	outpatien	t 3 DOA Othe	er: 4 🗌 Nursi	ing Home 5	Residence	6 ☐Other (Spec	city)
n of	ding Ph h. After th funeral		27. Manner of Death 1. Satural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Injury Work	y at k?	28d. Desc	cribe how inju	ry occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation			Yes 2 □ No				
Division	or At after c Direct in by	ertification;	4 Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, factory, office			tion (Street ar or Town, State		ral Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Conflict Sentifying Physician: To the best of my knowledge	le death	occurred at the tim	oe date and r	nlace, and due to	o the cousal?	Lant vannarss	alulus.
	e Hos 24 h e Fur	edical	(Check only 2 Medical Examiner: On the basis of examination a one)	nd/or inv	estigation, in my or	pinion, death	occurred at the	time, date and	d place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	e number		29d. Da	te signed (Month	n, Day, Year)
)			Daymerd Wille mo		D4	7683	3	7/	11/05	
	5		30. Name and address of person who completed cause of death (Item 23a)							
)		Raymon Milli 25 Main Street Sinte	200	· listert	own M	D 2113	6		
	Sta Registi		131. Date filed (Month, Day, Year) 32. Registrat's Signature JUL 1 3 2005	E.a.	188° - 186° -					
DH	MH 17 Rev 1/2	-	JOL I O COOD Phaline	186	AND WALL					

ORIGINAL

Beth huch

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:45 PM LeDedev Koman 2005 UNL /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan 15, 1943 5 Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplece (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 62 Director 219-41-4903 USSR Usual Residence of Decedent the Maryland show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.

Instit It leam 27 is marked other than "natural", or frame 23e or 28e-1 show mit: It leam or 21 is marked other than "natural", or other traumatic event, It is the lice Exaction must be notified at 1 ☐ Yes 2 ☑ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6113 Berkley Avenue Apt. B 21209 Funeral Russia 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ng most of working Elementary/Secondary (0-12) College (1-4or 5+) 10 Yrs Professor of Piano Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael 2 Lebedev Alisa Danishevsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saryana Kokotov Wife 6113 Berkley Avenue Apt. B Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 7/10/05 Hampstead, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Furneral Service Licensee Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-small Cell Lung Caner /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed t should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate 1 Yes To the Hospitel or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 2 1 Inpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural Injury 5 Pending 1 Yes 2 No investigation 2 Accident n 24 hours after death as Funeral Diractor: , detely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Dey, Year) D0030972 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Longwood Ry Buttimore MD 21210 Karen H. Gira 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

		State Registrar 1. Decedent's Name (First, Middle,	(act)	Ce	rtificate of		Reg. Date of Death	No. 2005	22860
Physician /Medica	1	Nadia Marie Les	•			2		07 2005	05:17p
Examine		la. Facility Name (If not institution, s 10401 Grosvenor			4b. City, Town, o Bethe	or Location of Death		4c. County of Deat Montgon	
Funeral Director	5	5. Social Security Number 321-03-1995	. Sex 7. A	ge (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye 11-18-1	9. Birt 913 I	hplece (State or Foreign untry) 11inois
M to	_ <u> </u> _	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Ba-f sh			gomery	North Be					1 ☐ Yes 2 🛣 No
3a or 2 at be n		10401 Grosvenor	sPlace #14	10	10f. Zip Code 2	0852		Citizen of What Co USA	untry?
it of realist and wenter regions in 19 liters 23 or 28a-1 show if them 27 is marked other than 'natural', or items 23a or 28a-1 show or other freumatic event, the Medical Executation and be notified at To Be Completed by Funeral Director	Dy ruilei	11. Marital Status 1 □ Never Married 2 □ Married 3 ত Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
"natur allest	ובונת	15. Decedent's (Specify only highest)	Education grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of working d)	16b	. Kind of Business/	Industry
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atic event,	ם ו	17. Father's Name (First, Middle, La Adolph Naumann	st)			18. Mother's Name (F Anna Sop	irst, Middle, Maid ohia Naut		
treum	Ī	19a. Informant's Name/Relationship Holly Ann Clema				and Number or Rural F			^{Tip Code)} gton NJ 085
Importent: If item 27 is any injury or other tre	-	20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pla	Ce) Date	9 20c	. Location - City or	Town, State
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any (c		21. Signature of Funeral Service Li	M	00382	Rapp Fun	eral & Cren Ave Silver	nation Se	ervice	
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signed b	1 by 1	Part II. Other significant conditions Myothermic Grav		but not resulting in the u	nderlying cause giv	ven in Part I.			the cause of death?
page 2 should t	analdino						24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
certificate rector, pag	ם ו	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death (C	Check only one)		
is is		1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inj	ury 28b. Time of	it 3□ DOA 28c. Injui Woi	er: 4 ☐ Nursing Home y at 28c	5 Residence d. Describe how in		eity)
death. ictor: Aft y the fun	Call	1 Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he		M 1	Yes 2 □No			
rs after death. al Director: After tool in by the funera		4 Homicide determine	289. Place of it	ijury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office	28f	. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner s	t of my knowledge, deatl of examination and/or in tated.	occurred at the time time of the stigation, in my o	me, date and place, and ppinion, death occurred	due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
들는 일 등	2	29b. Signature and title of certifier	14 B	,	29c. Licens			Date signed (Month	, Day, Year)
To		· Carol ~	- Bon	1/4/	D	17615 K	1d.	7/11/05	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 9, Year Physician 2005 6:40 P LORIS SHEILA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 15, 1937 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 2√ F Months Days Hours 68 106-28-1371 NY Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☑ No MD BALTIMORE Directo BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 HARNESS COURT #104 21208 USA filed within 72 hours after death Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ☐ Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) **BOOKKEEPER** AIR CONDITIONING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be find Mental H HARRY **GUTMAN** SYLVIA BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other tra once. LYNN LORIS OWENS / DAUGHTER 11044 HARDING ROAD - LAUREL, MD 20703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 💢 Removal from State 07/11/2005 PINELAWN, NY WELLWOOD CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatur of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Circhosis **Physician** neway billary Jears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law raquires that the death certificate be exacuted Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 1a months?

1 Yes 2 M No 23d. Date of delivery 3 □Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Souther (Specify) NOS Pile Certification: To 1 Tes 2 No in is 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Matural 5 Pending investigation s after dec. 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type Grint)

ARM N (HAWE) (M) (60) N; Challes ST POWSON MD ZIZENT AGRON CHARLES and 6601

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

Bloom I Aparle

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 20b.c per fh 8845 /-13-05 yr.

ע			For	Amend	Latems State of I	Marylan	d / Depa	th g845 artment o	of Health	and Me	ental Hy	giene	-		
		1	For State Registrar						of Death			Reg. No.	200	22	962
	Physicia /Medic		1. Decedent's Name (First, M	ddle, Last)		Mu	rohy	,			2. Date of Dea	Day 6,	2005 2005	3. Time of \$5:12P.	M M
	Examin	G	4a. Facility Name (If not institu UNIVERSITY HO		eet and numb	er)	, ,	1	wn, or Location	of Death		Ac. C	ounty of Death		
*	Funeral Director		5. Social Security Number	6. Sex	7. A 2 F		last birthday) 8 Yrs.	If Under 1 Y	rear If Unde Pays Hours	Min.	B. Date of Birt (Month, Da	h	9. Birth	place (State or	Foreign
	and		Usual Residence of Deceden 10a. State 10b. Cou			10c. Cit	y, Town or Lo	ocation						10d. fnside Cit	y Limits
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	with the	Director	10e. Street and Number	104				10f. Zip Co				10g. Citize USA	en of What Cou	intry?	
	ms 23	Funeral	519 Cumberlar 11. Maritaf Status		. Was Decede	ent Ever in U	.S. 13.	Was Deceden	t of Hispanic O Cuban, Mexica	origin? (Spec	fy Yes or No		I. Race - Amer Black, White		
036	72 hours after death with the Maryland "netural", or flems 23a or 28a-f show offest Exportment for notified at	by	1 Never Married 2	-	Armed Force 1 ☐ Yes 2, If Yes, Give Year or Date	No	1	1 ☐ Yes 2 €			ican, etc.)	s	Specify: Bla		
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	ed fa	To Be C	17. Father's Name (First, Mid							her's Name (11e Sh	(First, Middle,	Maiden S	iumame)		
Maryland	2 2 2 2 2		19a. Informant's Name/Relat	onship (Type	e, Print)			-		ber or Rural	Route Numbe	-	Town, State, Zi	p Code)	
Baltimore,	00= 5		20a. Method of Disposition Burial 2 Cremat	on 3⊟Rer	moval from St	ate 20b.		esition (Name		Da	te		TCUS ity or 1	own, State	
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Ba	permit. Depart Import any inj		Xon4 ()	1/1	nl		.59	O FREDI	irch Fun	ASS B	alto Mi	2012	19		
in.			23a. Party. Enter the disease shock, or heart failure.	or complica List only one	cause on eac	ch line.			of dying, such a	is cardiac or	respiratory ar	rrest,		Approximate Interval Betw Onset and D	veen
	Physician /Medical Examiner		Immediate Cayse (Final disease or condition resulting in death)	(a.		as a conseq		Cour	diova	Scelle	2Cd E	seas	e		
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V.	be executed sician and burial-transit	Examln	Cause (Disease or injury that initiated events resulting in death) Last) c.	Due to (or	r as a conseq	quence of):								
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9	death certifica attending ph if for use as th	/Med	IF FEMALE:	230	c. If yes, outco	ome of pregna	ancy					23	3d. Date of delin	190/	
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			h 2 ∏ Feta nt at time of d vn		⊒Ectopic preg ⊒ Other (spec					Month	,	'ear
Ω.	res that igned by be deta		Part If. Other significant cor	ditions contr	nbuting to dea	th but not res	sulting in the u	inderlying cau	se given in Par	t I.			e contribute to		
ord	v require been sk	eted	end stage	reno	ldis	ease	, Ca	cana	ma			Yes 2□			Inknown
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Vita	Physician: r this certificanal director,	o Be	25. Was case referred to me examiner? 1∑ Yes 2 □ No		spital: 1 □ Ing	a TX	ER/Outpatie		Other		(Check only o				
of	>	-	27. Manner of Death t Natural 5 ☐ Pe	ending restigation	28a. Date of		28b. Time of Injury		fnjury at Work?	28	Bd. Describe I		Other (Spec	iry)	
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be termined	28e. Place o building	of Injury - At h g, etc. (Special	ome, farm, st	reet, factory, c	iffice	28	Bf. Location (S City or Tox		Number or Ru	ral Route Numt	⊅e <i>r</i> ,
	Hospitel 24 hours Funerel stely filled	edical C				is of examina							and manner as place, and due)
	within 2 To the complet	Me	29b. Signature and title of ce	rtitier		\bigcirc	n		icense numbe		1		signed (Month	Day, Year)	
			Hotu	dis	-	tok	lel	~3	.C.M.E.			JULY	7,2005		
	3		30. Hame and address of pe	Aro	nicA-	- Hol	1AK+		PENN SI	REET,	BALTIMO	ORE M	ARYLANI	21201	
3	Sta Regist		31. Date filed (Month, Day,)	1 3 20	75 32. R	istrar's Signi	ature	here							

Physicia /Medic	an	Decedent's Name (First, Middle Thomas		Bennett	1	Mannina			Date of Dea Month	ath Day	y Ye	3. Time of
Aviedic						Manning			July 6	, 20	005	3:28
Examine	er	4a. Facility Name (If not institution, 1601 Aisquith S	Street	per)		4b. City, Town, or Baltimon	re			4c.	County of D NA	Death
Funeral Director		5. Social Security Number unk	6. Sex 7 1 X M 2 □ F	7. Age (In yrs. last 50		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month 3 Da	5-55	9.	Birthplace (State of Country) Md.
*		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ation						10d. Inside Ci
fahow	tor	Md.	NA		Balti	more						1 ₹Yes
r 28a	Irec	10e. Street and Number				10f. Zip Code				10g. Citi	izen of What	t Country?
23a c	a D	323 E. 25th St	reet			21218	}			U	SA	
- 3	by Funeral Director	11. Marital Status 1 ↑ Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford	2 X No		as Decedent of Hi Yes, specify Cuba	ispanic Orig in, Mexican, Specify:	jin? (Spe . Puerto I	cify Yes or No- Rican, etc.)		14. Race - A	American Indian, Vhite, etc. Black
nen "natu Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	's Education t grade completed) College (1-4)		(Give kır life. DO	nt's Usual Occupa nd of work done of NOT use retired	during most	of workii	ng	16b. Ki	ind of Busine	·
her th	Co	12th grade				Laborer	40.44.4		120		Varie	:S
Mental H Marked ot Matic ever	To Be	17. Father's Name (First, Middle, L James	C	Cartwrigh			N	ancy			Manni	
h and 7 is m Iraum		19a. Informant's Name/Relationsh		Sister		Address (Street a						
Healt am 2 ther	l a	Margaret Cartwi	rigit s	20b. Place	of Dispositi	Fontana			ttimore			or Town, State
t: If It		t√□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		tate ceme	itery, cremai	cem		7–13				
ortan ortan injur		21. Signature of Funeral Service L		-		Name and Addres			Baltimo			e, Md.
Depe Impo eny ir		1 gabuel	les Cr	V)	19	March F.	28V 1522	0.3			North	21202
hysician /Medical xaminer	her	snock, or near failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Methad	used the death. Ech line. lone into	oxicat	the mode of dying	g, such as c	eardiac o	r respiratory ar	rest,		Approximate Interval Betw Onset and E
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wx with the speed of the attending physicien and with this certificate hes been signed by the attending physicien and will be detached for use as the burial-transit or page 2 should be detached for use as the burial-transit or page 2.	To Be Completed by Physician/Medical	Snock, or near rainte. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lary leading to in reclatic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Methad Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outco 1 Live bin 4 Pregnal 9 Unknow his contributing to deal Hospital: 1 Ing 28a. Date of 7 - Morro	Injury Year) Ione into Into into into into into into into into i	oxicat ce of): ce of): ce of): g in the under Outpatient c. Time of	ctopic pregnancy Other (specify) erlying cause give	an in Part I. 26. Place o	of Death sing Horr	23e. Did to 1	obacco u yes 2\bar{1} an sy med? 2 \bar{1} No ne) ence 6	Month se contribute No 3 24b. Were prior 1 death 1 2 Y	delivery Day a to the cause of delivery Day autopsy findings a to completion of calls yes 2 \(\subseteq \text{No} \)
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			For State Registrar		State of I	Marylar				ealth a Death	and Me		giene Reg. No	~ ~ -	5	22	864
	Dhysisi	22	1. Decedent's Name	(First, Middle, Las	t)						1	2. Date of Dea Month	ath Day	,	/ear	3. Time	of Death
	Physici /Medic	_	Stanley	Мс	Combs, S	Sr.						06	30)5	12:	20P M
	Examir	er		not institution, give		er)				Location o				County of			
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	Funeral Director		5. Social Security N 578-60-5	026	x	58	last birthday) Yrs.	Months		Hours	Min.	3. Date of Bird (Month, Da 08 22	y, Year)		Cou	D.C.	or Foreign
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ity, Town or Lo	ocation		-			-		1	0d. Inside	City Limits
	Maryl I sho	tor	MD	MOntgome	ery	I	Damascu	ıs								₽E Ye	es 2 □ No
	h with tha 3a or 28a st be noti	Funeral Director	10e. Street and Nur 10815 Si	nber Lr Barton	Circle				p Code 0872				_	zen of Wi USA	at Cou	ntry?	
936	igas 1 and 2 should ba filed within 72 hours aftar daath with tha Maryland it of Haatih and Mantal Hygiana. If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Example must be notified at	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 ☑ Married 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	∋s? □ No			edent of Hi ecify Cuba 218 No		gin? (Spec i, Puerto R	ify Yes or No ican, etc.)	-		Americ White, B1a	4	
21215-0036	within 72 ho ana. than "natur he Medical I	Completed	(Spec	15. Decedent's Edify only highest grad		or 5+)	16a. Dece (Give life.	kind of w		turing most	t of working	,	16b. K	ind of Bus	iness/In	dustry	
21	giana giana artha	E O	12th	1.			En	gine	er					erox			
Maryland	12 should ba filed within in and Mantal Hygiana. 7 is marked othar than "traumatic event, the Med	Be	17. Father's Name	(First, Middle, Last)								First, Middle,		Sumame)		
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	parmit. Pagas 1 and 2 Dapertmant of Haalth a Important: If Itam 27 is any Injury or othar trai <u>once</u> .		20a. Method of Disp		JCC1	20b.	Place of Dispo cemetery, cre	osition (Na	ime of		Da				ity or To	own, State	
Baltimore,	Pagas ant of nt: If I			☐ Cremation 3 ☐ 5 ☐ Other (Specify		ate	aryland				7-14-	05	Che1	tenha	am.	MD.	
Ħ	parmit. Pa Dapertman Important: any Injury			neral Service Licen		ric						hall's					
ä	Dape Impo any Ir		100	ma	ulul	2						Washin					
	Physician /Medical		23a. Part Enter should be	le disease, or comp it failure. List only o (Final in	aLiv	sed the dea th line. er Fai as a conse	ilure	ter the mo	de of dyin	g, such as	cardiac or	respiratory a	rrest,			Approxim Interval B Onset an	etween
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8760,	cate ba axacuted physicien and tha burial-transit	dical Examiner	that initiated events resulting in death)	5		atitis as a conse											
O. Box 6	tha daath cartific y the attending p chad for usa as	Physician/Mec	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	h 2 ☐ Fet nt at time of	al death 3	⊒Ectopic p ⊒ Other (s	pregnancy					23d. Date Mont		ery Day	Year
rds, P	Se Co	by	Part II. Other signi	ficant conditions of	ontributing to dea	th but not re	sulting in the u	underlying	cause giv	en in Part I		23e. Did t				ne cause o ably 4 [f death?
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/ita	Physician: 1 this certificat ral diractor, p	Be	25. Was case references	<u> </u>	Hospital							(Check only o					
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on	ding h. Aftar fune	tlon	1 X Natural 2 Accident	5 Pending investigation	28a. Date of (Month,	Day Year)	Injury	м	28c. Injun Worl	yat k? Yes 2□		d. Describe	now inju	y occurre			
Division of	= 5 to €	Certification;	3 Suicide 4 Homicide	6 Could not be determined	286. Place o	f Injury - At t , etc. (Spec	home, farm, st	reet, facto	ry, office		2	3f. Location (City or To	Street an wn, State	nd Number)	or Rur	al Route N	umber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one)	1⊠ Certifying Ph 2 Medicel Exam		is of examin											e(s)
	To the within 2 To the compla	¥	29b. Signature and	title of certifier	4.0			25	9c. Licens				29d. Da	te signed	(Month,	Day, Year)
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Î	0		30. Name and add		completed cause												
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			For	State of Maryland				l Mental Hygi	A A -	0000
			For State Registrar		Cer	tificate of L	Death		g. No2 U 0 5	22865
	Physicia		1. Decedent's Name (First, Middle, Last)	- 0				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	MARGARET . 4a. Facility Name (If not institution, give st		ζ	4b. City, Town, or	Location of De	JULY	4c. County of Dea	
	Examin	er	- 1	oursing Hol	no		NIUM	ani	BACTIM	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 H	rs. 8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		216-19-5969 10	M 32 F 81	Yrs.	Months Days	Hours Mi	n. (Month, Day,	1,1924	PA.
	D .		Usual Residence of Decedent 10a, State 10b, County	10a Cit	. Town or Lo	antina			·	10d. Inside City Limits
	ehov	2	10a. State 10b. County 10b. CALT				RIVER			1 Yes 2 No
	the M	ecto	10e. Street and Number	mare	10.	10f. Zip Code	1 10 010	10	ng. Citizen of What C	ountry?
	with	흐	509 Nollmey	er RD			220		U.S.A	
	ns 23	Funeral Director	0011	2. Was Decedent Ever in U.	S. 13. y	Vas Decedent of H	spanic Origin?	(Specify Yes or No-	14. Race - Am	
9	or Iter	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cuba	Specify:	eno Hican, etc.)	Black, Whi	
21215-0036	hours after death with the Maryland ture!; or Items 23a or 28a-f show al Examinat he modified at	d by	3☐Widowed 4 ☐ Divorced	Year or Dates:					, ,	uhite
5	netu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of v	vorking	16b. Kind of Business	s/Industry
12	within iene. r then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homem	,		Home.	
	filed Hygi sther		17. Father's Name (First, Middle, Last)	200			18. Mother's N	lame (First, Middle, A		
Maryland	Mental Nental rked c	o Be	Richard Mur	P 14 4			MARG	Aret 1	RAIley	
ary	s 1 and 2 should be t Health and Mental Item 27 Is marked other traumatic ev		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	•		Rural Route Number,		
	s 1 and 2 of Health a Item 27 Is other trace		BARBARA LUTZI		509		YER F	CD. BALF		120
ore	ges 1 it of He if Iter or oth		20a. Method of Disposition → □ Burial 2 □ Cremation 3 □ Re	emoval from State		sition (Name of natory or other place	(8)		20c. Location - City o	
Ë	Pages Iment of I tent: If It		' 4 ☐ Donation 5 ☐ Other (Specify)	GAR	RISON	forest c	rem.	15/05	wings 1	Mills Ms
Baltimore,	permit. Pages Department of I Importent: If Ite any Injury or of		21. Similare of Funeral Service License	Still	14	-ARTLEY	Miller .	-STEllA	FUNERAL I	Mills Ms. Home CHTD.
	40144		23a. Part. Enter the disease, or complic	ations that caused the death		20/11/21	1010/	43. 134116		Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				9190		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequ		- 1 2	5 CVL	on di	CLAFE	
E	Examiner				,					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause puisease or injury	Due to (or as a consequ	uence of):					
V	acutec ind transi	Examine	that initiated events cresulting in death) Last							
90,	cate be executed physician and the burial-transit		resulting in death, cast	Due to (or as a consequ	dence or);					
8760	cate ohys	dlcal	d							
9 x	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	elivery
Вох	death atter	clar	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
0	at the de by the a	hys	9 Unknown	9□ Unknown						***
э, Б	es tha Igned I be det	ру Р	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
ord	v require been sig should b		DEMENT	_				_ 1 \ Ye	es 2□No 3□F	Probably 4 Unknown
Vital Records,	has be	Completed	GC son/o	and Suhre	55 4			24a. Was a autops	y prior to	autopsy findings available completion of cause of
Ξ.		Con						perform 1 Yes 2		
Vita	olcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		oth Oth	00	Death (Check only on		
of	Phys this at dii	. To	1 Yes 2 No	1 Unpatient 2 U	ER/Outpatier 28b. Time o	IL 3 DOA	Nursin	g Home 5 Reside	ence 6 ∐Other (Sp ow injury occurred	ecify)
	After After	tlon	1 Detural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No		, ,	
Division	Attendi r death. octor: A by the fu	Ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or F	Rural Route Number,
ă	s after	Certification:	4 Homicide	building, etc. (Specif	y)			Ony or Your	, 51416)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	edical (29a. Certifier 1 Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina	wledge, deat	h occurred at the til	ne, date and pl	ace, and due to the co	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	the H hin 24 the F nplete	Medi	one)	and manner stated.		29c. Licens			9d. Date signed (Mor	
	To To con	-	29b. Signature and title of certifier	·	. ^			1		
	,		1	moleted cause of death (free	V)	Print)	1350	7	,-1(MS 21093
	4		30. Name and address of person who co			100 Dula	ines 11a	den M	Timonium	Ms 21093
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	- 1		1 1 2 1		
	Regist		JUL 1 3 20	05 Magree .	K	hoel !				

				For State Registrar	State of M	aryland		artment ertificate					005	22856
				Decedent's Name (First, Middle, Last,)						2. Date of De	ath		3. Time of Death
_		Physicia		Robert Leroy N	lann, Sr.						July	11,	2005	8:55 P M
		/Medio Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or Lo	cation of Death		4c. Cc	ounty of Death	1
		e .		Atlantic General	Hospital			Be	erlin			Wo.	rceste	た
		Funeral Director		5. Social Security Number 6. Se 218-10-8815	7. Ag	90 (In yrs. Ia 85	ast birthday, Yrs.	Months [Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov. 2	th y, Year) 1919	9. Birth Cou	place (State or Foreign Intry) LYLAND
		p ,		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or L	ocation						10d. Inside City Limits
		ehov	'n			Too. Only		cean Ci	i +					1 (X) Yes 2 □ No
		28a-1	Director	Maryland Worceste 10e. Street and Number	<u>r</u>		00	10f. Zip C				10g Citize	n of What Cou	
		with the corr		179 Pine Tree Ro	ad			101. 2100	218	42		u.s		
		ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Deceder	nt of Hispa	nic Origin? (Sp	ecify Yes or No	- 14	Race - Amer	
3	36	iiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow ith, it a Macilcal Estricitation to the recilised at	by Funerai	1 □ Never Married 2 🛱 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	1	If Yes, specify 1 ☐ Yes 2		Mexican, Puerto Specify:	Rican, etc.)	Si	Black, White	_
Kpined: 2055 (855pm)	21215-0036	72 hours aft "natural", or		15. Decedent's Edu	ication		16a. Dece	edent's Usual (Occupation	n ng most of work	rina	16b. Kind	of Business/l	ndustry
٧٢ ا	215	within 72 ho ene. than "natur	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	retired)	ig most of work	9	4.	0.4	O.
000		ad wil	Con	10th Grade			St	eelwork					o Stee	l .
3	nd	12 should be filed w h and Mental Hygie 7 ie marked other t traumatic event, II.	Be	17. Father's Name (First, Middle, Last) Norman Mann					18	. Mother's Name Agnes	e (First, Middle Moxl		imame)	
5)	χ	ould Men Marke Marke	ို		D.:-		40h 14-ii	in a delenna /6	Ctroot and	Number or Run			Tourn State 7	in Code)
8.	Maryland			19a. Informant's Name/Relationship (T) Mr. Robert L. Many		anl				oad, Oc			2184	
3		s 1 and 2 f Health item 27 i		20a. Method of Disposition	19 2/10 (2)	20b. Pl	ace of Disp	osition (Name	e of		Date		tion - City or T	
3	Saltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				ematory or other USLAUS		7/14/	2005	Balti	more.	Maryland
g	Ė	artme ortan injur		21. Signature of uner Service Cens		5/1.				Facility Sch				
III	B	permit. Departn Imports any inju		190167	la					Rd., B				
				23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause	d the death	. Do not er	nter the mode	of dying, s	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	110	051	M	10						Onset and Death
U		/Medical		resulting in death)	Due to (or as	a conseq	ience of):							
<u></u>		Examiner		Sequentially list conditions,	b									
يخ کچ	—	p ii	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):							
62-1919 - 3005		cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):							
21	8760,	be exician buria												
= -	387	phys phys the	dicai		d									
ی د	×	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23	d. Date of deli	very
ည် ဋ	ğ	The law requires that the death Ite has been signed by the atter bage 2 should be detached for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			☐Ectopic pred ☐ Other (spec					Month	Day Year
26	00	res that the digned by the be detached	hys	9 Unknown	9□ Unknown									
	Œ.	es tha igned l	by P	Part fl. Other significant conditions co	ntributing to death i	but not resu	ilting in the	underlying cau	use given i	n Part I.				the cause of death?
و نـ	ΣĒ	v require been sig should b									1 🗆	Yes 25	No 3□Pro	obably 4 Unknown
4 8	ခပ္ပ ၁မ	law re as be 2 sh	Completed						·		24a. Was auto	DSV	prior to c	topsy findings available completion of cause of
be	H.	sician: The law certificate has b lirector, page 2 s	Com									ormed?	death?	2□ No
8	ia	cian: ertific	Be (25. Was case referred to medical examiner?		-				3. Place of Deat	th (Check only	one)		
-0	<u> </u>	Physic this c al dire	2	1 Yes 2 No	Hospital: 1 Inpati		ER/Outpatie			4 Nursing Ho	ome 5 Resi			cify)
3	<u>ر</u> ة 25	Jing P	ion	27. Manne of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time fnjury	of 280	c. Injury at Work?	2 □ No	280. Describe	now injury t	occurred	
<u>8</u> ,	isio	death death stor: , the (icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of In	iury - At ho	me farm s			20.10	28f. Location (Street and I	Number or Ru	ral Route Number,
_	Divisi	Hospital or Attend 24 hours after death Funeral Director: etely filled in by the f	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify	<i>')</i>	inost, fastory,	011100		City or To	wn, State)		
		spita		29a. Certifier 1 Certifying Phy	/sician: To the besi	t of my know	wledge, dea	ath occurred at	t the time,	date and place,	and due to the	cause(s) ar	nd manner as	stated.
		To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat the Funeral Director. After the gompletely filled in by the funeral director, page	edicai	(Check only 2 Medical Exam	iner: On the basis and manner s		ion and/or i	investigation, ii	in my opini	on, death occur	red at the time,	date and p	ace, and due	to the cause(s)
_		within To the Comple	ž	29b. Signature and title of certifier		1.	/	29c.	License nu	umber		29d. Date	signed (Month	n, Day, Year)
	•	1		1 lun	P	my 516	1/1	11	144	1283		7/1	12/0	1
/	141	1		30. Name and address of person who o	completed cause of	death (Item	23a) (Type	Print)		Λ.	,	P	0.	BA
,	71					112	1 14	(2/N	204	11/1	· /	ser	xen,	110
		Sta Registi		31. Date filed (Month, Day, Year)	32. Hegisi	trar's Signal	uite	H. A.	sie	1				
	DH	MH 17 Rev 1/2	.). .	JUI	1 8 2005	De	Biff	10 100						
	2.1		1											

			1 - For State Registrar	State of M	aryland		artment tificate			nd Me		giene Reg. No	กกต	22867
	Physic		1. Decedent's Name (First, Middle, Las Charles Nelson	7	Jr.						2. Date of De Month JWLU	Day	2005	
	/Medi Examir		4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·			4b. City,	Town, or	Location of		July		county of D	7:52 P M
			Manor Care Nrsng 5. Social Security Number 6. Se		- Ross	i	If Under		ille If Under 2	d Uro I a			Balt	
В	Funeral Director			ZM 2□F /. A9	82 82	Yrs.	Months	Days	Hours	Min.	B. Date of Bir Month, Da Feb. 2	y, Year)	23 Ma	Birthplace (State or Foreign Country) UYLANd
_	and and		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation							10d. Inside City Limits
	vith the Marylan or 28e-1 show be notified at	tor	Maryland Baltimo	re		Ва	ltimo	re						1 ☐ Yes 2 No
	with the Maryland to or 28e-1 show	Director	10e. Street and Number 9203 Kilbride Ro	and			10f. Zip		0102/			10g. Citize	on of What	•
	death w	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. V	Vas Decede		21236		ifv Yes or No	. 14	U.S.	A.
36	or Ite	by Fur	1 Never Married 2 Married	Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	No	1	Yes, spec		, Mexican, Specify:	Puerto Ri	ify Yes or No ican, etc.)		Black, W	hite, etc.
21215-0036	n 72 hours naturel', edical Ex	ted b	3 Widowed 4 Divorced 15. Decedent's Edi	ucation		16a. Deced	ent's Usual	Occupa	tion				d of Busine	
1215	within 7, ene. than 'n	Completed	(Specify only highest grad	de completed) College (1-4or 5		(Give I life. D	kind of worl OO NOT us	k doné di e retired)	iring most i	of working		Maryl	and T	ransit
d 21	be filed withintal Hygiene. Id other then		12th Grade 17. Father's Name (First, Middle, Last)			Bu	s Dri		18. Mother	's Name (First, Middle,	Autho Maiden S		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, ITe Mi	To Be	Charles Nelson I	McMann, S			_		Ma	rgar	et B	rogan	1	
Mar	iges 1 and 2 should nt of Health and Men i. If Item 27 Is marke or other treumatic		19a. Informant's Name/Relationship (T. Mrs. Pearl M. McMo								Route Numbe ltimor			
ore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 It any injury or other tre oncg.		20a. Method of Disposition 1		20b. Plac	ce of Dispos	ition (Nam	e of	1	Dat				or Town, State
Baltimore,	permit. Pag Department Importent: I any in ury o		4 Donation 3 Other (Specify,)	Par	kwood				/12/2	2005	Balt	imore,	, Maryland
Ba	permit. I Departm Importer any inju		21. Signature en runeral/Service Ligages	688		9	Na <i>m</i> e and 7 <i>05</i> B	l Address Lli	of Facility.	Schin , ba	nunek Limor	Funer e. MD	al Ho 212	mes 36
	Physician /Medical		23a. Part 1. Enter the disease of comp shock, or he in tailur at Lift only of Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lie a		Do not ente	r the mode	of dying						Approximate Interval Between Onset and Death
В	Examiner	_	Sequentially list conditions,	b	CER	CRLO	VAS	. Cul	HL	P	CCID	SNIT		
	uted d ansit	Examiner	Sequentially list conditions, if any leading it mediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	nge utj:								
8760,	cate be executed bhysician and the burial-transit	I Exa	resulting in death) Last	Due to (or as	a consequer	nce of):								
687		edlcal		d										
.O. Box	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3 🗆 🛭	Ectopic pre Other (s <i>pe</i>			_		230	d. Date of d Month	elivery Day Year
rds, P.	w requires that been signed t should be deta	by	Part II. Other significant conditions co	ntributing to death b	ut not resultii	ng in the und	derlying ca	usa given	in Part I.				_	to the cause of death? Probably 4 Dunknown
Records,	siclen: The law requiscentificate has been irector, page 2 should	Completed								_ '	24a. Was autop perfor	med?	24b. Were a prior to death?	
		BeC	25. Was case referred to medical examiner?						26. Place o	of Death (C	1 Yes	2 10 No	1 🗆 Ye	s 2 No
of V	> 0 0	2	1 ☐ Yes 2 € No 27. Manner of Death		nt 2 EA			ARREST CARDIOLO	4 TNUIS		5 Resid			ecify)
		ation	1 Accident investigation	28a. Date of Injur (Month, Day	Year)	Bb. Time of Injury	M 28	c. Injury a Work? 1 🔲 Ye	ıt ıs 2∐No		d. Describe h	ow injury o	ccurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, stree	et, factory,	office		28f	Location (S City or Tow	treet and M	Number or F	Rural Route Number,
Ω	spitel o		29a. Certifier 117 Certifying Phy	sicien: To the best of	of my knowle	edge death	nccured at	the time	date and	place and	t due to the	201100/0\ 00	d	
	To the Hospite within 24 hours To the Funerel completely filled	Medical	one)	ner: On the basis of and manner sta	examination	and/or inve	estigation, i	n my opir	nion, death	occurred	at the time, o	late and pl	ace, and du	s stated. se to the cause(s)
	T with	2	29b. Signature and title of certifier					License (29d. Date s	igned (Mor	nth, Day, Year)
1	04/	2	30. Name and address of person who co	ompleted cause of de	path (Item 23	Ba) (Type, P		: گکا	900			Jucy	, 1 (2005
			DENVIS IF ODIE	9106	191 Los	0511	hin &	-0)	June	= 2	00 B	ANO	MI	21277
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL. 1	3 2005 Negistr	r's Signature	A. A. S.	Jan.							· —

		-	For State Registrar	State of	Marylan		artmen					_	0.0.5	
	Physicia		Decedent's Name (First, Middle Ana Gloria Ort				imour	0, 1	Journ		2. Date of Dea Month 07	Day	2005	2та 8оби8 06 10рм
	/Medic Examin		4a. Facility Name (If not institution 18045 Wheatric	, give street and numb					Location of		07	4c. Co	ounty of Death	
	Funeral Director		5, Social Security Number	6. Sex 7. 1 ☐ M 2/5xF	Age (In yrs. 58	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 05-15	h y, Year) -1947		place (State or Foreign http) Salvador
	Aaryiand Febow	or	Usual Residence of Decedent 10a. State 10b. County MD Mont	gomery		y, Town or Lo							1	0d. Inside City Limits
	or 28a-	Direct	10e. Street and Number				10f. Zip						of What Cour	ntry?
98	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23s or 28s-f show he Medical Exp. iliter is ust be mullied at	by Funeral Director	18045 Wheatric 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2	es? [☑No		Was Deced If Yes, spec	fent of Hi offy Cuba		igin? (Spe	ocity Yes or No Rican, etc.) alvador		Race - Americ Black, White, pecify: Whi	etc.
Maryland 21215-0036	be filed within 72 hou stal Hygiene. od other than "natural event, the Medical E.	Completed h	15. Deceden			life.	dent's Usua kind of wo DO NOT us eaches	rk done d se retired	lurina mos	st of worki	ng		of Business/In	,
and 2	ould be filed within Mental Hygiene. Rarked other than satic event, the Me	Be	17. Father's Name (First, Middle, Hector Villand			1					(First, Middle,	Maiden Su	mame)	
Maryl	and and is m	<u>م</u>	19a. Informant's Name/Relations Maritza Carper	hip (Type, Print)			-		and Numb	er or Rura	d Route Numbe	•		
a)			20a. Method of Disposition 1 ★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 ☐Removal from St	1 0	Place of Disponentery, creation Marc	sition (Nar	ne of			eate 6-2005	20c. Locat	tion - City or To Salvado	own, State
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	okimar	M003	82 22	Rapp 933	d Addres Fund Gist	s of Facili eral Ave	& Cr Silv	emation er Spri	Serv	ice 20910	
760,	Priyocian /Medical Examiner pura sician and pura l'tausit	icai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Enter Indentyin, Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or	ised the death line. AUCE ras a consequence as a consequ	uence of):	er the mod					rest,		Approximate Interval Between Onset and Death MONTH S
.O. Box 687	death certificate e attending phy. d for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ∏Feta ntattime of d	ldeath 3	ĴEctopic pi ☑ Othe <i>r (sp</i>					23d	I. Date of delive	ery Day Year
S, D	uires that t signed by ild be detac	by	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying o	ause give	en in Part	l.	23e. Did t			he cause of death?
Record	The law requires that the ate has been signed by the page 2 should be detache	Completed											prior to co death?	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2	ER/Outpatie	nt 3 🗆 DC	Oth	ar.		n <i>(Check only o</i> me 5 M esic		Other (Specif	(y)
on of	ding Phys h. After this funeral di	tion: T	27. Manner of Death 1	28a. Date of (Month, igation	Injury Day Year)	28b. Time of Injury	f 2	8c. Injun Worl	/at k? Yes 2□		28d. Describe l	now injury o	occurred	
Division	To the Hospital or Attending Phwith 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place o	f Injury · At h	ome, farm, st	reet, factor	, office	_		28f. Location (3 City or Tox		Vumber or Rura	al Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Direct Completely filled in by	Medicai C		ng Physician: To the b Examiner: On the bas and manne	is of examina									
)	To th within To th	M	29b. Signature and title of certifie	er M1	D		290		6 16			29d. Date s	igned (Month,	Day, Year)
111-	6		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type,	-3 (00	1 #:	327	Olve	4 , M	11-20 D 206	932
	Sta Regist		31. Date filed (Month, Day, Year,	3 2005 32.	gistrar's Signa		Carle	9	- 41		t	1	-	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month omas Mor 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c/County of Deal Examiner Burnie -len Longe If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace **Funeral** Months Days Hours Min. 245-18-1742 1**∑**M 2□F Director NOV. 2 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show 17 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at lamore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 2408 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🕱 No Black 3 Widowed 4 Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) river 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Mental 1e lous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health : If item 27 | 2408 10 Mallor Ra 12h 20b. Place of Disposition (Name of cametery, crematory or other place) Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F
4 Donation 5 Other (Specify) 0 3 Removal from State permit, Page Department of Important: If any Injury or once. YUNIT Zaw em Name and Address of B 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia 10 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use es the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of) been signed by the attending physician should be detached for use es the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? U1-8 a 2 No 2 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 Tyes 25**Z**No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) tuneral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a To the Funeral C To the Hospital 1 Securifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 300% al Charles 5 wit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medica Bultimone Cente 301 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registra 3 2005

			_ For	State of M	laryland	d / Depa	artment o	f Health	and Me	ntal Hy	giene	0005	22070	
			1 - State Registrar	dla dia and		Cei	rtificate (of Death			Reg. No.	.003	22870	_
	Physici /Medic Examin	al	1. Decedent's Name (First, Midd 4a. Facility Name (if not instituti	ouise S	she	4	McD 4b. City, Tow	owti	11	Month	Day	Year 20 County of De	05 15: 34 PM	_
	Funeral Director	0,	5. Social Security Number 441-20-7944 Usual Residence of Decedant		HOSP ge (In yrs. Ia 80		If Under 1 Y	ear If Under ays Hours		Date of Birt (Month, Day 03-20-	h y, Year) -192	9. B	inthplace (State or Foreign Country) klahoma	_
	f show	or	10a. State 10b. Coun	rfax		Town or Lo	ecation						10d. Inside City Limits 1√2 Yes 2 □ No	_
	with the h 3a or 28a-i it ke notifi	Funeral Director	10e. Street and Number 7720 Tremayne				10f. Zip Cod	de 2210	2		10g. Citi	zen of What (Country?	_
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural', or Itema 23e or 28e-f show amy injury or other traumatic event, If a Mardical Exert in at most ke notified at once.	þ	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Spivorce	If Yes, Give	? No		Was Decedent If Yes, specify 6	of Hispanic Or Cuban, Mexica No Specify:		y Yes or No- ean, etc.)		14. Race · An Black, Wh Specify: W		
21215-0036	within 72 horane.	Completed			5+)	(Give life.	dent's Usual Or kind of work de DO NOT use re rnalist	one during mos etired)	st of working		16b. Ki	nd of Busines Media	·	_
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Maryland	nd 2 shoul lith and Me 27 is mari	Ė	19a. Informant's Name/Relation Robert M. McD	nship (Type, Print)				reet and Numb Courtho						_
Baltimore,	Pages 1 au nent of Hea nt: If Itam iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Eremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State	e ce	imetery, crei	osition (Name of matory or other lke Crer	natory	Date 07-08	-2005		cation - City o	or Town, State	-
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8760,	ate be executed hysician and the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):	RIGHT	E EAN	r ien				2 WEEKS	3
Box 6	ath certific ttending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregn Other (specif				2	3d. Date of de Month	elivery Day Year	
ds, P.O.	uires that he de signed by the a ld be deta hed f	by	9 ☐ Unknown ² Part II. Other significant condi	tions contributing to death!	but not resu	Ilting in the u	nderlying cause	e given in Part I	l.	23e. Did to			to the cause of death? Probably 4 Unknown	-
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Division	i di di	Certification;	3 Suicide 6 Coul 4 Homicide deter	mined 286. Place of In	njury - At hor etc. (Specify)	me, farm, str	eet, factory, of	fice	28f	Location (S City or Tow			Rural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1. Certify (Check only one)	ring Physician: To the best al Examiner: On the basis of and manner s	of examinati	wledge, deat ion and/or in	h occurred at the vestigation, in r	ne time, date ar my opinion, dea	nd place, and ath occurred	due to the dat the time, d	ause(s) date and	and manner a place, and du	as stated. ue to the cause(s)	
)	To the within 2 To the complet	Σ	29b. Signature and title of certif					cense number			1		nth, Day, Year)	
	16		30. Name and address of person	nul MEDIC on who completed cause of	ALD death (Item	23a) (Type,	Print)	ES-0	00	<	Juli	16,	4005	
	(5) Sta	te	AND CZARNIK 31. Date filed (Month, Day, M	THE TOHPS	HOSH Mays Signat	SINS HO	SPITALIA	DONCON	l wolfe	E STRE	ET, E	SALPMO	2005 RE, MARYLAND	7
	Registr		30	T 1 9 7002			1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200522871 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month JUL YDay B. **Physician** 2005 02:24PM **EDWARD** MILLER LESLIE /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | APR.17,1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√M 2□F 213-48-6274 55 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23e or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE **NOTTINGHAM** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8348 POPLAR MILL ROAD 21236 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕻 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION AUTOMOTIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill thent of Health and Mental H tent: If itam 27 is marked off jury or other traumatic evan SANFORD MILLER anna SINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8348 POPLAR MILL ROAD - NOTTINGHAM, MD 21236 MARCIA MILLER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If any injury or once. ANSHE EMUNAH (AITZ CHAIM) 7/11/05 ELKRIDGE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of): OBSTRUCTIVE SLEEP APNEA **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and il-transit To the Hospitei or Attending Physician: The law requires that the death certificate be executed OBESITY Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS been sign Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2基 No ACUTE RENAL FAILURE has certificate After this certific funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Diractor: A 2 Accident 6 Could not be determined within 24 hours after devanthin 24 hours after development of the completely filled in by the 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263

Registrar

State

7601 OSLER DRIVE TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 1 3 2005

32. Registrar's Signature

FRANCIS KHOO M. D.

31. Date filed (Month, Day, Year)

		Please	Type or Prin					•	_	gible.	
		For State	State of Ma	aryland.	-	artment of F <i>rtificate of</i>	lealth and N	lental Hyg	iene		
		Registrar 1. Decedent's Name (First, Middle, Lateral	20			lilicate of	Dealli	2. Date of Dea	eg. No.)	05	2 2 0 7 2
Physic			Daniel, Ji	r .				July 10), ^{Day} 200	5 Year	12:52 AM
/Medi Exami		4a. Facility Name (If not institution, give	<u>-</u>			4b. City, Town, o	r Location of Death	1		nty of Death	
LXaii		Gilchrist Center F	or Hospice	9		Towson			Balt	imore	
Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthp	place (State or Foreign
Director		243-24-3003	X M 2□F	76	Yrs.			Oct. 9,	1928	Nort	h Carolina
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
Mary -f sh	to	Maryland Baltimor	re	Midd	le Ri	ver					1 ☐ Yes 2 (X)No
h the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen o		ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. The Medical Examinar must be notified at anones.	a D	22 Diehedral Drive				21220			U.S.	Α.	
tams	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,	
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y ould ould warke	မှ	William Royce McDa					Mary Ett		O: T		0-41
VICAL 12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Mildred Gage McDar					and Number or Rur Drive, Ba				
1 and 1 and Healt am 2		20a. Method of Disposition	iter (Mire)	20b. Place	e of Dispo	sition (Name of	1		20c. Location		
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Lxaiiiiici	-	Sequentially list conditions.	b. — Due to (or as	a consequen	ce of):						
ted	nin	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury	540 10 10 40	a 55116544511	00 01)1						
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			For State	State of M	laryland / De	partment ertificate	of Health	and Mental	Hygiene 0 (05 22873
	专家		Registrar 1. Decedent's Name (First, Middle)	e, Last)		Crimoato	OI DOUIN	2. Date o	f Death	3. Time of Death
	Physici: /Medic		Anna	М.	Nash			July		005 11:10 a ^M
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			987 Miller Ci		ge (In yrs. last birtho		nsville Year If Under	24 Hrs. 8 Date of		Arundel 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 215-10-9152	1 M 2 K F	89 Yrs	Months [Days Hours	Min. June	of Birth Day, Year) 20,1916	Country) Maryland
	D		Usual Residence of Decedent		100 City Town	- Landing				10d. Inside City Limits
	show	2	MD Anne	Arundel	10c. City, Town o	sville				1 ☐ Yes 2 🛣 No
	the M	Director	10e. Street and Number			10f. Zip C	ode		10g. Citizen of	What Country?
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	ems ?	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	3. Was Deceder	nt of Hispanic Or Cuban, Mexica	igin? (Specify Yes on, Puerto Rican, etc	r No- 14. Rad	ce - American Indian, ck, White, etc.
36	be filed within 72 hours after death with the Maryland tal Hyglene. ad other than "neturel", or Items 23a or 28e-f show event, the Madical Evanirat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Mar 3X Widowed 4 ☐ Divorced	If Yes Give	X ¹ °	1 ☐ Yes 2 X			Specif	White
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ore,	es 1 a of He f Item r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from Stat	20b. Place of Di cemetery,	sposition (Name crematory or othe	of er place)	Date	20c. Location	- City or Town, State
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Вох	leath certifica attending ph	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Fetal death	3 □Ectopic preg	nancy			ate of delivery
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of \	유무교	10	1 Yes 2 No	Hospital: 1 _ Inpa		tient 3 DOA	Other: 4 🗆 Nu	ursing Home 5/14	ribe how injury occur	ner (Specify)
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			· The	cey_	nex		W 2 00	79	0+/	11/08
	10		30. Name and address of person	Gorbaly	nin (pe, Print)	1ad Jan	Park	Drug,	(Co Burniqued,
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				State of Marylar		rtment of F tificate of			jiene 1eg. No,2	05	22071
	D		1. Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month	10703	Year	3. Time of Death
	Physici /Medi		ARTHUR	J. 2000	J, JR	å		7		05	9:45Am
1	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or L		4c. County	_	
			Maryland Masoni 5. Social Security Number 6. Security Number		. last birthday)	If Under 1 Year	Cockeysvi			altim	
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	ס		Usual Residence of Decedent					FED. 7,	1)1)	IRALY	Tarid
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	ns 23	Funeral Director	300 International	12. Was Decedent Ever in t	J,S. 13. V	Vas Decedent of H	LIODO dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - America	
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat require be notified at once.	by Fur	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cub. ☐ Yes 2 No		Rican, etc.)	Specify	ok, White, e v: Wh	otc. iite
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Maryland	shou ind M	-	19a. Informant's Name/Relationship (Ty	oe, Print)		-	and Number or Rur				Code)
	end 2 saith a n 27 is		Judith N. Grey/day	THE PERSON NAMED IN COLUMN 2 I				Monkton	<u> </u>		
Baltimore,	ges 1 t of H		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	emoval from State		sition (Name of natory or other pla			20c. Location -	•	
ţ	t. Partmen tant:		4 □ Donation 5 □ Other (Specify)			matory,		11/05	Baltin		MD
Bal	Depar Impor any ir		21. Signature of Funeral Service License	Honald	1 2	99 Frede	ss of Facility Society crick Road	Raltin	more M	nc. D 212	.28
			Dawn F McDor 23a. Part1. Enter the disease, or complishock, or heart feilure. List only or	cations that caused the dealer cause on each line.	th. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arm	est,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	End ?	Haze	Denei	ten:			1 1	Onset and Death
		er	roodaling in doubly	Due to (or as a consequ	uence of):	2 - 10	2.			
	outed nd ransit	edical Examiner	Sequentially list conditions		or as a consequ		mun	mse.	24		
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Вох	eath certif ettending 1 for use as	clar	Dad II Other simulficent conditions			4044	on in Deal	OOL Distan			tha causa of death?
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Division of Vital Records,	uires n signi ld be	d by	hio kidny St	,	-	V		24a. Was a		24b. We	re autopsy findings
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∑_<	hysic his ce	ို	1 ☐ Yes 2 No		ER/Outpatient	OL DOA		me 5□Reside			1
E C	Ing P	io.	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injur Wor M 1□	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurr	ed	
/isid	To the Hospital or Attending Physician: The is within 24 hours effect death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h				28f. Location (St	reet and Numb	er or Rural	Route Number,
á	tal or is efte	Cert	4 Homicide	building, etc. (Special	(y)			City or Towr	1, State)		
	Hospi 24 hou Funer rtely fill	Medical	(Check only 2 Medical Examir	Icien: To the best of my known; On the basis of examina	owledge, death ation and/or inve	occurred at the tinestigation, in my o	ne, date and place, pinion, death occurr	end due to the ca red at the ti <i>m</i> e, da	ause(s) and me ate and place, a	nner es ste and due to	ited. the cause(s)
	o the o the omple	Med	one) 285. Signature and title of certifier	and manner stated.		29c. Licens	e nu <i>m</i> ber	2	9d. Date signed	d (Month, D	ay, Year)
	F3F8		Pr	best in		T) > 1 \ / /		7/11	105	
	201	ii .	30. Name and address of person whico	mpleted cause of death (Iter	m 23a) (Type, F	Print)	XIXOV		/	, –	
	0		ROBGET LIBERTO,	MD. 3508	Brus	c st	Ball Ball	i, Mic	(21	12	4
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature 15	Analls!					

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Amend 1 tems 10f, 19b, 20b per fh 8645 7-13-05 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 **Physician** 10:05 P ^M 10, JULY STEWART NOLEN /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6000 CEDAR COURT CARROLI ELDERSBURG If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | DEC. | 9, 1957 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 2 F **Funeral** Months MD 47 218-72-0700 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No **ELDERSBURG** CARROLL MD Direct 10g. Citizen of What Country? 10f. Zip Code 21784 10e. Street and Number -21874USA 6000 CEDAR COURT deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Peges 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: WHITE þ 3 Widowed 4 Divorced natural the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER COMPUTER ANALYST marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever (UNOBTAINABLE) NOLEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21784 6000 CEDAR COURT - ELDERSBURG, MD 21874 Department of Health a Important: If itsm 27 is any injury or other tra once. BARBARA NOLEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS 12 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EVERGREEN MEMORIAL $07/\frac{11}{2005}$ FINKSBURG, MD 21. Signature Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. W 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause en each tirge. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 ding physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached o 9 Unknown signed by t d be detach Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 2 No 1 Tyes should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No To Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2NO 2 ER/Outpatient 3 DOA s after dea... 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signalu e and title of certifi who completed cause of death (Item 23a) (Type, Print) Wastmister,

DHMH 17 Rev 1/2001

State Registrar egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** CAROL Κ. OFFUTT JULY 1:50 A.M 12, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-23-1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Min. Months Days Hours 1□M XXF 216-66-9950 65 MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ir items 23a or 28a-f show drier r-ust be notified at XXYes 2 □ No Director CITY MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1013 KENWOOD AVENUE 21224 U. S. A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes X2X No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: WHITE ᇫ Specify: other treumatic event, the Madical Example If Yes, Give Year or Dates: 3 Widowed 4 Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 7 nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF **EMPLOYED** ARTIST YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be 2 should be f and Mental H KING NORRIS SVEC MARIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Heelth and Importent: if Item 27 is n any injury or other treum 14504 FALLING LEAF DRIVE, GAITHERBURG, MARYLAND, 20878 DAVID K. OFFUTT (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State HILLTOP SERVICE CORP. 07-13-2005 TOWSON MARYLAND, 21204 4 ☐ Donation 5 ☐ Other (Specify) 1050 YORK ROAD 22. Name and Address of Facility 21. Signature of Funeral Septine Licansee (R.G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ceukemia MYCKOGINOUS Montas Physician /Medical MyclofiBrosis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on. Examiner burial-transi Due to (or as a consequence of): the attending physicien 68760 certificate be Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗀 Yes 2 🗋 No 3 🗀 Probably 4 🕻 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 X No 1 ☐ Yes 2□ No Yes Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 ☐ Residence 6 X Other (Specify 105 P(4 Hospital: 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 124 hours after death. 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 ho To the Fune completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 58303 JULY 12 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NORTH CHARLES STREET, TOWSON, MARYLAND, 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		State of Maryland				ental Hyg	iene	
		Registrar	Cei	rtificate of Dea			eg. No 2 A A S	2-0 0-3-5
Physicia	n	1. Decedent's Name (First, Middle, Last) Sarah Louise Osing			2	2. Date of Deat Month	Day Year	Z. I prie Death
/Medica		4a_Facility Name (If not institution, give street and number)		4b. City, Town, or Local	tion of Death	VIV 1	4c. County of Death	00,224m
Examine	ŗ	St Conse Has aital		Po Hoose	NON OF DORIN		40. County of Double	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)		nder 24 Hrs. 8	. Date of Birth	9. Birthi	olace (State or Foreign
Director		214-16-4125 1 M 2 S F 83	Yrs.	Months Days Hou	urs Min.	June 26	Year) 9. Birthy Cour , 1922 Mary	land
pu »	-	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	ocation				10d. Inside City Limits
fanyla sho	5							1 ☐ Yes 2 ☒ No
28a-1	Director	Maryland Howard 10e. Street and Number	FITIC	ott City 10f. Zip Code		1	0g. Citizen of What Cou	ntry?
death with the Maryland ms 23a or 28a-f show ringst be notified at		4703 Ribble Court		21043			U.S.A.	,
ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S		Was Decedent of Hispania	c Origin? (Speci	fy Yes or No-	14. Race - Ameri	
after or its	2	Armed Forces? 1 Never Married ZK Married Armed Forces? 1 Yes, Give		If Yes, specify Cuban, Me 1 Yes 2 No Spe	жісап, Ривпо ні эсіfy:	can, etc.)	Black, White,	etc.
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withigh	E C	Elementary/Secondary (0-12) College (1-4or 5+)		ffice Clerk			Social Secu	ıritv
id 2 filed Hygi other	Be C	17. Father's Name (First, Middle, Last)			Nother's Name (First, Middle, M	Maiden Sumame)	illoy
rlan Jid be Menta Ric ev	ToB	John W. Waters		My	rtle Ro	se Bowe	en	
Maryland 21215-0036 to 2 should be filed within 72 hours att the and Mental Hygiene. 27 is marked other then "naturel; or traumatic event, the Medical Exert.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and No				· ·
and and and mark		John Osing, Sr. (Husband)		Ribble Cour				
Baltimore, sermit. Pages 1 ar abpartment of Heam mportant: If tiem inty injury or other tothe.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	metery, crei	osition (Name of matory or other place)	Da		20c. Location - City or To	
itim t. Pa rtmen rtmnt:				ce Crematory		2005 B	Beltsville,	Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating an once.		21. Signature of Funeral Service Licensee	W	2. Name and Address of F Jitzke Funera	al Home	of Cat	onsville, I	nc.
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		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	· -	HOOK FO	1100			Interval Between Onset and Death
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8760, cate be exphysician the burial	E E	5 20 10 (81 25 2 5013542	51100 01).					
687 ficate physis the	edical	d				-		
S, P.O. Box 6 es that the death certificity of the attending 1 be delached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		75			23d. Date of delive	эгу
Geath death of for	cla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of de		□Ectopic pregnancy □ Other (s <i>pecify)</i>			Month	Day Year
at the by the stacks	hys	9 Unknown						
IS, P. P. igned b	þ	Part II. Other significant conditions contributing to death but not resu	, -		Part I.		pacco use contribute to ti	
cords w requires been sign should be	ted	ARF - Acute Renal Fo	TICHE			1 🗆 Ye		oably 4 🗍 Unknown
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o the ithin 2 or the comple	Mec	29b. Signature and title of certifier		29c. License num	ber	25	9d. Date signed (Month,	Day, Year)
F3 F 5		Daniel AB-house		D 18	2609	7	Tuly 10	2005
		30. Name and address of person who completed cause of death (I)em	23a) (Type,	Print)	001	Δ.	- 7	7000
4		Dr. Daniel Abraha	um	900 (aton	Ave	talT.	T.D. 21209
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			for State Registrar	State of Maryland	d / Depa			Mental Hyg	jiene	05 000=
	Physici /Medio Examin	al	Decedent's Name (First, Middle, La Julia C. 4a. Facility Name (If not institution, gin	Poulson		4b. City, Town,	or Location of Dea	2. Date of Dea Month		Year 2 Non M
	Funeral Director			Nursing Home Sex 7. Age (In yrs. I	last birthday) Yrs.	Hyatt If Under 1 Year Months Days		. (Month, Day	, Year)	9. Birthplace (State or Foreign Country) Wash. D.C.
th the Maryland	or 28a-f show a notified at	Director	10a. State 10b. County D • C • 10e. Street and Number		y, Town or Loo			1	Og. Citizen of V	10d. Inside City Limits 12€ Yes 2 □ No What Country?
J36 urs after death w	nal Hygiene. od other than "naturai", or itams 23a or 28a-f show avant, the Medical Examiner must be notified at	by Funerai	4829 4th Stree 11. Marital Status 15 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		2001 Vas Decedent of Yes, specify Cult	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or No- to Rican, etc.)	1	A se - American Indian, ck, White, etc. y: Black
27273-0036 ed within 72 hours aft	ygiene. ser than "natura t, the Madical E	Completed	15. Decedent's Elementary/Secondary (0-12) Unknown	ade completed) College (1-4or 5+)	(Give i life. E	ent's Usual Occu kind of work done OO NOT use retire	during most of wo		U.S.	usiness/Industry Government
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			21. Signature of Funeral Service Lice 23a. Part 1 Enter the disease, or conshock or heart failure. List only	plications that caused the death	4.2 n. Do not ente	17 9th. er the mode of dy	St. N.W.	Washing c or respiratory arr	ton, D.	
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Of VITAL ME Physician: The la		o Be Comp	25. Was case referred to medical examiner? 1 ☐ Yes 2₽No	Hospital: 1 Inpatient 2	ER/Outpatient	27 DOA 01		autops perfori 1 ☐ Yes ath (Check only on Home 5 ☐ Reside	med? control of the c	prior to completion of cause of death? I ☐ Yes 2☐ No
DIVISION OF i or Attending Phy	death. ctor: After y the fune	Certification; To	27. Manner of Death 1 1 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. inju Wo M 1 [ury at ork? ∃Yes 2 ⊟No	28d. Describe ho	ow injury occurr	
pitai o	urs afte eral Dir	edicai Certi	29a. Certifier 1 PCertifying P	hysician: To the best of my knor miner: On the basis of examinat and manner stated.	wledge, death	occurred at the testigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time, d	ause(s) and ma	anner as stated. and due to the cause(s)
) of 1	within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier 30. Name and address of person who	Completed cause of death (Item	1 23a) (Type, I	29c. Licen	se number	2	9d. Date signed	d (Month, Day, Year)
7	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrary Signal 1 3 2005	ANDOL ture	forte	500181			1113 66763

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Examin		4a. Facility Name (If not institut	tion, give street and i			b. City, Town, or	Location of D	eath	4c. C	ounty of Death	
Lxairiii		SHADY GROVE	ADVENTIST	T HOSPITAL		ROC	KVILLE		MC	NTGOME	RY
uneral Director		5. Social Security Number	6. Sex 1 2 M 2 □ F	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir (Month, Da	iy, Year)	Cou	place (State or Forei ntry)
		Usual Residence of Decedent						uni/Qia-		COVI	
Mot =		10a. State 10b. Cour	nty	10c. City, Tox	wn or Loca	tion					10d. Inside City Lim
28e-f show notified at	Director	unknown un	Kuam		ankn	nun					1 🗌 Yes 2 🗍 I
or 28	le	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?
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and mental hygiene. Is marked other than eumatic event, ILEM	2	unknown					unk	nown			
S THE		19a. Informant's Name/Relation	nship (Type, Print)	19	b. Mailing	Address (Street a	and Number or	Rural Route Numbe	er, City or T	own, State, Zi	Code)
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f item r othe	1 1	20a. Method of Disposition			of Dispositi	on (Name of ory or other place	e)	Date	20c. Loca	tion - City or T	own, State
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Importent: If item 27 any injury or other tr		21. Signature of Funeral Service Ronald S.		DAB	22. N St	ame and Addres ate Anal Itimore,	s of Facility	ard, 655			
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/Medi Exami		4a. Fecility Name (If not institution, g	give street and number)		4b. Cit	v. Town. or l	Location of D	-	JONE		2005	8 90 17
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uneral				(In yrs. last birti	hday) If Und	er 1 Year	If Under 24 Hours		Date of Birth (Month, Day	Year)	9. Birthpl Coun	lace (State or Fore
irector		Usual Residence of Decedent	1L M 2125 F	14 Y	rs.				-10-1	930		MD
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rai', or items 23a or 28a-f show Examiner must be notified at	ctor	MO BALTIN	MORE	CATONS	BVILLE							1 □ Yes 2 🗷
or 28	Director	10e. Street and Number	10			Zip Code			1		of What Coun	try?
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ritem	Funerai	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? d 1 ☐ Yes 2 🗷 N		If Yes, sp	ecify Cuban	spanic Origin n, Mexican, P	uerto Rica	an, etc.)		lack, White,	
France	b	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 M No	Specify:			Spec	city: BLA	ICK
an "natural" Medical Ex	etec	15. Decedent's (Specify only highest of	Education grade completed)	16a.	Decedent's Us (Give kind of v	vork done du	uring most of	working		16b. Kind of	Business/Ind	lustry
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	To B	CLIFTON WILLIA	MS				ROSA	DA	VIS			
S E E		19a. Informant's Name/Relationship			Mailing Addre				_			
item 27 other tr		EARL PAGE 20a. Method of Disposition	(SON)	20b. Place of		RIAGI	E WA	Date	REDR		MD n - City or Tov	21702
2 = 2		1 KBurial 2 ☐ Cremation 3		cemetery	r, crematory of	r other place,	· 1					
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		shock, or heart tarrure. List on	ly one cause on each lin	e.	ot enter the m	ode of dying,	, such as car	diac or re	spiratory arre	est,		Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09 05 /Medical Facility Name (If not institution, give street and num A/TIMORE RECREATION 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARE N/A If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 1 M 2 € F Yrs. 17,1927 Director Austria 222-24-0069 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or itame 23a or 28e-1 ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Chase Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21220 7167 Olivia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filad within 72 hours atter neat of Health and Mental Hygiene. and I fitem 27 ie marked other than "natural", or its any or other traumatic event, I'm Modical Examina ury or other traumatic event, I'm Modical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ģ 3 □Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerical Secretary 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helene Hasslicht Wilhelm Schramm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7167 Olivia Road Chase, Maryland Karen Long (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Hilltop Service Corp. 7/12/2005 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Bnd Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this certificate has autopsy performed 2 No 2 X No 1 Yes 1 Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 4648 3210 BALTIMORE MD 21218 3900 LOCHRINEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pasturini **Physician** 2005 /Medical July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2019 Haverford Drive Crownsville Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 25, 1946 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral XX**M 2□ F Yrs. Director 095-36-8319 58 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 is marked other than "naturel", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or Items 23a or 28a-f show treumatic event, It a Madical Ever it at mast be notified at 10d. Inside City Limits Director MD Anne Arundel 1 ☐ Yes 2 ☐ No Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2019 Haverford Drive 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Graphic Designer Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Pastorini Arlene Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is r or other tree Carolyn Pastorini (Wife) 2019 Haverford Drive, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Calverton Nat'l Cem. 07-11-2005 Calverton, NY 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 00 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 2 1 No 2 No 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Punerel Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) Within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 043236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Anderson 2448 Annapulis, md 21401 Holly Ave Ste 100 3 2005 JUL Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0323 AM Po 10011 2005 FRANCES 04 ひいし /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Columbia HOWARD HOWARD County General If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Year) | Nov 4 1933 Birthplace (State or Foreign Country)
 C 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Yrs. 71 219-32-9455 Director Usual Residence of Decedent deeth with the Marylend 10c City Town or Location 10d. Inside City Limits 10a. State 10b County "natural", or flems 23a or 28a-f show digal Examiner must be notified at 1 ☐ Yes 2 ☑ No Jessup MD Anne Arundel Direct 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 20796 USA 9950 Guilford Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Ma Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked oth any filury or other traumatic svent 2008. Be Inez Tucker Bennett Chester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6519 Overhart Road, Columbia, MD Brenda Clark - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 7/9/2005 Beltsville, MD Chesapeake Crematory Inc. ^{22. Name and Address of Facility}
CAFA, Stephen D. Lohrmann, PA
8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Licens - MOO986 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1RIER ORDNARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transli ettending physician and Due to (or as a consequence of): Physician/Medical use es the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ğ 4 Pregnant at time of death 5 Other (specify) P.0. detached the 9 Unknown The law requires that the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? peubis Division of Vital Records. ģ 90 CARDIO VASCULAR 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 ☐ Yes 2 ☐ No certificete 2 110 Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: Hospital: 2 D NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes Certification: To Sin funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Attending 1 Natural 5 Pending within 24 hours efter deeth.

To the Funerel Director: A completely filled in hours. deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ŏ 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie JULY 6, 2005 128079 prier no 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 2 DORSSIC HALL IR. SCLTE (03 FRANCINE A · Lt. 668 -SHIPHUND MS ELLICOIT CITY UN 31. Date filed (Month, Day, Year) 32. Registrari Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No.) G. Amed Baths 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:L7 AM 07 10 Riggs /Medical Kevin Α. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□ F Months 38 Director 09 11 66 Wash. D.C 2**15-04-**7847 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County r then "netural", or Itame 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD Prince Georges Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5516 Helmont Drive 20745 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U. S. Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Importent: If Item 27 is marked other to any Injury or other treumatic event, ILL ODG. 12th. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAmes Riggs Vernice Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vernice Smith/Mother 5516 Helmont Dr. Oxon Hill, MD. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State 7-14-05 Lincoln Memorial Suitland, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Marshall Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Neumones /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Disknown as been signal Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate ha 2□ No 1 Yes 20110 1 Yes Hospitel or Attending Physicien: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗀 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check o one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature 504 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address SILVER SPRINIMO 980 3-41 en 31. Date filed (Month) 32. Registrar's Signature Day, Year State Registrar 3 2005

ORIGINAL

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	State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death		g. No. 200 E	2222
Physician	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	अट्टांल कि कि
/Medical	KELVIN DEAN ROBERTSON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	July	8 2005 4c. County of Death	4:16 P [™]
Examiner			NA	,
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	year) 9. Birtl	nplace (State or Foreign
Director	230 · 27 · 8 923 IMM 2 F 25 Yrs. Months Days Hours Min.	03.23.10	180	nplace (State or Foreign untry) GA
death with the Maryland ons 23e or 28e-f show if must be notified at neeral Director	10a. State 10b. County 10c. City, Town or Location BALTIMORE			10d. fnside City Limits 1 Yes 2 No
uter death with the Maurer trems 23s or 28s-f singler must be notified Funeral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
eath weath we say	The state of the s	ecity Yes or No-	14. Race - Ame	ncan Indian,
9 2 3 J.J	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Power Married 2 Married 1 Power Married 2 Power Married 3 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto It Yes, Give Year or Dates:	Rican, etc.)	Specify: 181	a, etc. ACK
72 hour natural utgal Ex	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 1	6b. Kind of Business/	
d 2 should be filed within 72 hours aft with and Mental Hygiens of 18 marked other than "natural", or traumatic event, the Medical Exerta To Be Completed by F	Etermentary/Secondary (0-12) 12 TH GRADE COllege (1-4or 5+) N A CABINET MAKER		FURNITU	8E
ntal Hygin of other sevent, I Be Cc	17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle, Ma		
and Mental is marked o aumatic eve	19a. Informant's Name/Relationship (Type, Print), 19b. Maifing Address (Street and Number or Run	al Route Number,		ip Code)
fealth and 2 fealth a mm 27 is her tra	MEWIN ROBERTSON (FATHER) H. N. TREEMONT RD. 20b. Place of Disposition (Name of		10 21229 0c. Location - City or	Town State
Saltimore, beautile, Pages 1 ar Department of Hea mportant: If them not lightly or othe page.	1 M Rurial 2 Commation 2 Removal from State cemetery, crematory or other place)		ANDALLSTO	
permit. Pages 1 and 2 Department of Health a Important: If tiern 27 it eny Injury or other tra gnce.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNI 5151 BALTO. NATUPIKE, E	erai servi	c£	1010
8 A 25 M.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician /Medical	fmmediate Cause (Final disease or condition resulting in death) a. Multiple Guishty Wounds			
Examiner	Due to (or as a consequence of):			
sit sit	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury			
te be executed ysician and be burial-transit	resulting in death) Last Due to (or as a consequence of):			
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onding I use as	IF FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Date of def	•
requires that the death certificateen signed by the attending phyholid be detached for use as the hould by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown		Month	Day Year
res that the de signed by the a loe detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
The law requires the cate has been signed page 2 should be completed by		1 Tes		bably 4 Unknown
The law The law page 2 s		24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of 2 No
sician: The certificate irector, pag	25. Was case referred to medical 26. Place of Deal	th (Check only one		22110
Physicia this cert at direct	- 7		nce 6 ⊡Other (Spec	cify)
Attending Physician: Tridath. ector: After this certification: After this Certification: To Be C	27. Manner of Death 1	28d. Describe how	Winjury occurred	107
LIVISION OF VITAIN TRECOLUS, teal or Attending Physician: The law requires the state death. The incorpor: After this cartificate has been signed in by the funeral director, page 2 should be contification: To Be Completed by	2 Accident investigation 3 Suicide 6 Could not be determined elemined building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Ru State) 26.33 No.33	ral Route Number
rs after all Direction	ST/est	2.11	wire mi	r rocoper sha
To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, which is the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cau rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier 29c. License number OCME	29	d. Date signed (Monti	n, Day, Year)
7	JWI. Lit			2005
5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street	et Balti	more, Mary	land 21201
	31. Date filed (Month, Day, Year) 32 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** July
4b. City, Town, or Location of Death 8, 2005 RHODES 7:50 PM WILLIAM MILES /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☑ M 2 ☐ F Director 89 August 4, 1915 Virginia 218-20-6181 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature" any injury or other traumatic exceptions. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Somerset Crisfield 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 26688 Johnson Creek Road 21817 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. IXYes 2□No World 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: War II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Seafood 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Rhodes Vesta Miles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26635 Old State Road - Crisfield, MD 21817
Disposition (Name of Date 20c. Location - City or Town, State Frank Rhodes (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 7/12/05 Crisfield, MD Asbury Cemetery 22. Name and Address of Facility Mary Beth Bradshaw-Pruit Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? is certificate has been signed by the director, page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PNEUMONIA ASPIRATION þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 410 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

od (Month Day, Year) 2005 3 Aegistrar's Signature July 1 3 2005

Specific

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Mont

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day DOLOMON DDOC 11:52 AM /Medical 12 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES Baltimore If Under 1 Year If Under 24 Hrs. HEALTH CARC-5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days 1 M 2 □ F Months Hours 251-18-1240 Sout Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-1 show 10d. Inside City Limits event, the Medical Examiner must be notified at Director MARYLAND 1 ☑ Yes 2 ☐ No 10e. Street and Number og. Citizen of What Country? or items 23a or 300 TERRACE 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 22 No 3 Widowed 4 Divorced BLAC Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 HGRADE STEELWORKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any lightly or other treumstic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAM VINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 POPLAR MAE W. SOLOMON (WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1∑8urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 7-20-05 OWINGS MILLS 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN -ULTON AVE. BALTO, MD. 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Respiratory fair Due to (or as a consequence of): **Physician** failure due pulmonary embolism to 2 weeks /Medical **Examiner** Coagulopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (dr as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Renating the property of the p Anemia, Prostate Cance Peliphe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director. Variable Disease 26. Place of Death (Check only one) 1 Inpatient Other: Medical Certification; To 2 ER/Outpatient 3☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 ☑Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17600 12 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) RUPAM A MITIKIRI, CATON AVE 900 5 BALTIMORE, 21229 31. Date filed (Month, Day, Year) Registrar's Sign tare State JUL 1 3 2005 Registrar

OLOMON

Baltimore, Maryland 21215-0036

amend item#11, perFH, C845, 7/13/05 11
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 0416 AM July 2005 10 Dolores Shifflett Anna /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glen Burnie Washington Medical Center Anne Arundel Baltimore If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Days Hours Min. Yrs. Director 220-09-5539 Mar. 19.1922 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the notified at once. 10a State 10b. County 1 ☑ Tes 2 ☐ No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 East Hamburg Street 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 10 Specify: Completed by 3 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Wachter Pletz Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2010 Poplar Ridge Road Pasadena, Maryland 21122
of Disposition (Name of Date 20c. Location - City or Town, State Carlissa L. Tucker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 7/13/05 Glen Burnie, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21. Signature of Fyneral Service Licenses Collins 21122 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** der me Car disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner lla Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events berte usion The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death jo in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 Pregnant at time of death 5 Other (specify) i signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Joder 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 1 No this certificate 1 Yes o the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 129b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Amble 1465 ashree 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore All Tay beter 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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1 3 2005

amend item/1,17,16 per MD, Inf., 8845, 7/20/05 IT Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Farideh Fatemeh Esfandiary Sadjadi Month **Physician** IGALGAS SEANDIARY FARIDEH 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOUTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. timere oresten 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months 078-28-6403 1 □ M 2(X) 79 Director 02-25-1926 IRAÑ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD. BALTIMORE LUTHERVILLE 1 ☐ Yes 2**\(**\)\(\)\(\)\(\)\(\) Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1810 DULANEY VALLEY ROAD 21093 U. S. A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: WHITE Specify: à 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fited withIn 7 Hygiene. Elementary/Secondary (0-12) HOUSEWIFE OWN HOME permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Important: If Item 27 Is marked other that any Injury or other traumatic event, Italy 2002. YEARS 4 Abolhassan Sadigh Esfandiary Mothe Montarian Family Esfandiary MOHTARAM SFANDIARY 17 Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MORAD EGHBAL (SON IN LAW) 9555 FRIENDSHIP STATION, WASHINGTON, D.C., 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) PARKLAWN CEMETERY 07-13-2005 ROCKVILLE, MARYLAND 1050 YORK ROAD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility (R.G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician PANCRESTIC Adeno CARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Undarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the f yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? 2 🗆 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending 1 Natural efter death. investigation 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Hospital within 24 hours of To the Funeral 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of Charles St. Baltimore MI) 31204 Robert 6701 INCR m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

3 2005

			1 - For State C	of Maryland / D	•	tment of Heificate of L				
	Physici		1. Decedent's Name (First, Middle, Last) Dorothy Mary	Schmitt	307.			2. Date of Death		9:05 PHM
	/Medic Examir		4a. Facility Name (If not institution, give street and no Stella Maris	ımber)		4b. City, Town, or Timoni	Location of Death		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day January 15	9. Birth 9. 1921 Man	nplace (State or Foreign unity) Cyland
	Maryland a-t show	ctor	Usual Residence of Decedent 10a. State MD Baltimore	10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2 📉 No
	3 with the	I Dire	10e. Street and Number 16 Nightingale Way			10f. Zip Code 21 0	93	10	og. Citizen of What Co	untry?
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other treumstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 12. Was Dec Armed F	No No	lf Y	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 hor sne. Ihan "naturi is Wedical I	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	(Give ki	nt's Usual Occupa ind of work done d O NOT use retired) maker	ition luring most of work)	king	Own home	ŕ
Maryland 2	ould be filed with Mental Hygiene. arked other than atic event, the	To Be Co	17. Father's Name (First, Middle, Last) Clarence	darmon			18. Mother's Nam	e (First, Middle, N		
	and 2 should lath and Men 7.27 is marke or treumatic		19a. Informant's Name/Relationship (Type, Print) Charles Schmitt-son						City or Town, State, 2 Meyers, FL	ip Code) 33908
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: It Item 27 Is any injury or other tree		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)		ry, crema	tion (Name of Mory or other place ice Corpora	9)		Towson, MD	Γown, State
Balt	permit. Depart Import any in		21. Signature of Funeral Service Licensee [uli]]	am G. Dau	1	Name and Addres 50 York Rd.	s of Facility Ru , Towson,	ick Tawsan I MD 21204	Funeral Home,	Inc.
	Pnysician /Medical Examiner		resulting in death) Due to	caused the death. Do reach line. EMIC COLITI (or as a consequence of	LS	the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dicai Examine	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of						
P.O. Box 6	The law requires that the death certific at has been signed by the attending progge 2 should be detached for use as	Physiclan/Med	in the past 12 months?	atcome of pregnancy birth 2 Tetal death mant at time of death nown		ctopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to	death but not resulting in	n the und	derlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
Il Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	prior to c	topsy findings available ompletion of cause of 2 No
Division of Vital	Attending Phy or death. ector: After this by the funeral d	Certification; To Be	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date (Mo investigation 6 Could not be determined 28e. Place determined 28e. Place determined	e of Injury - At home, fa ling, etc. (Specify)	Time of Injury	et, factory, office	at at at at at at at at at at at at at a	City or Town,	nce 6 10ther (Spec w injury occurred eet and Number or Ru State)	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only one) 2 Medical Examiner: On the and ma / 29b. Signature and title of certifier	basis of examination and nner stated.	nd/or inve	29c. License			d. Date signed (Month	
į	11		30. Name and address of person who completed cau				15/25		1/12/0	.5
	Sta			00 DULANEY Registrar's Signature			TIMONIUM	MD 210	93	
L	Regist	ar	JUL 1 3 2005 L	Hegistrar's Signature	Good					

		•	For State Registrar		State of Ma	-		artment of 1 <i>rtificate of</i>			ental Hy	_	ie io. 2 ()	105	2200
F	Physicia	an	1. Decedent's Nam								2. Date of D Month	eath C	ay	Year	3. Tinte of Peau
Η.	/Medic		Edgar		Harris , give street and number)			Sugg 4b. City, Town, o	or Location	on of Death	July	9	200. lc. County		12:00 a ^M
	Examin	er			ood Manor			Miller					Anne		do1
	un au al		5. Social Security 1			e (In yrs. last birt	hday)	If Under 1 Year			8. Date of B	irth			
	uneral rector		237-78- Usual Residence of	6990	1 M 2□ F		rs.	Months Days	Hour	s Min.	8. Date of Bi (Month, D Feb.	9,19	48	Nort	lace (State or Foreign try) h Carolina
aryland	show	_	10a. State	10b. County		10c. City, Town								1	0d. Inside City Limits
W e	8e-f	Director	MD	1	rundel	Glen	Bur								1 □ Yes 2 □ No
Aith th	or 2	풉	10e. Street and Nu		D 1			10f. Zip Code				10g. (Citizen of V	Vhat Coun	itry?
ath v	8 23a	ra	404 D.	Secret		E	140	2106		0-1-1-2 (0	* W		USA		an Indian
be filed within 72 hours after death with the Maryland hall Hygiene.	itan 27 is marked othar than "natural", or items 23a or 28e-f show other traumatic event, it a Modical Examinati-ust be rutified at	by Funeral	11. Marital Status1 ☐ Never Marital3 ☐ Widowed		12. Was Decedent Armed Forces? 1 K Yes 2 I If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🌠 No			Rican, etc.)	0-		e - Americ k, White, Wh	
n 72 hou	"natura edical E	Completed			t grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during n	nost of workin	g	16b.	Kind of Bu	isiness/Ind	dustry
with ene.	Is marked other than aumatic event, the M.	duc	Elementary/Second 1	ondary (0-12) 2	College (1-4or			e Engine					Meti	ro	
Hygi	othar ent.		17. Father's Name	(First, Middle,	Last)					ther's Name	(First, Middle	, Maide			
id be	ked ic ev	To Be	David R	obertso	n Sugg				Ph	oebe J	ane Ha	arri	s		
shou nd M	mat	-	19a. Informant's N	lame/Relations	nip (Type, Print)	19b.	Mailir	ng Address (Street	t and Nui	nber or Rural	Route Numi	ber, City	or Town,	State, Zip	Code)
and 2 should ealth and Mer	27 Is		Barbara	Sugg (Wife)	40	4 E	Secret	Bend	, Glen	Burni	ie,	MD 21	1061	
s 1 a	itam		20a. Method of Dis			20b. Place of	Dispo	sition (Name of natory or other pla		T***	ate		Location -		wn, State
Pages ment of	lent: If jury or		` 4 □ Donation	5 Other (S		1	Cr	ematory		7-16-			timoı	ce, M	D
permit. Depart	Importent: If itam 27 is any injury or other tra once.		21. Signature of Fi	uneral Service	License		22	Name and Addre Hardesty 12 Ridge	ess of Fa Fun ly A	cility eral H venue,	lome, I	P.A.	s, MI	214	01
ate be executed	physician and mide and midel-transit burial-transit burial-transit burial-transit control of the province and midels and	edicai Examiner	23a. Part1. Enter shock, or hes immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	art failure. List (Final on onditions, mmediate erlying r injury s	b. Oue to (or as	a consequence of a cons	VE of):	-		as cardiac or			,		Approximate Interval Between Onset and Death YEARS
the death certifi	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	ру				23d. Date Mor	e of delive	ry Day Year
uires that	signed b	by	1.00mm	BETE	ons contributing to death b			_	ven in Pa	rt I.		tobacco Yes		ibute to th	e cause of death? ably 4 Zunknown
e law req	has beer ge 2 shou	Completed					-				24a. Was		l p	Vere autor	osy findings available inpletion of cause of
_	ficate or, pa	e Co	05 Mar 2010 1010	and to madical							1 ☐ Yes	300	io 1	Yes	2□ No
sicia V	certi	o Be	25. Was case refe examiner? 1 ☐ Yes 2.5	,	Hospital:	ent 2 ER/Out	nation	- 27 DOA Ott	han A	ace of Death			C 🗆 Омь.	/0	
5 £	r this	-	27. Manner of Dea	No ith	28a. Date of Inju (Month, Da			28c. Inju	iry at	Nursing Hom	8d. Describe				")
ding 5	: Afte	tlor	1 Natural 2 Accident	5 Pendin investig	9	y Year) Ir	njury	Wo	ork?]Yes 2	□No					
or Attan	To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Place of Inj	ury - At home, far c. (Specify)	m, str	eet, factory, office		2	8f. Location City or To			er or Rura	l Route Number,
ospital hours a	unaral I		29a. Certifier (Check only	1 Certifyin	g Physician: To the best Examiner: On the basis o	of my knowledge	, deatl	n occurred at the ti	ime, date	and place, a	nd due to the	cause(s) and ma	nner as st	ated.
tha F	the F	Medical	опе)	7	and manner st	ated.									
To	2 00		29b. Signature and	title of certifie	7 .1.00	0		29c. Licen:			A. A. A. A. A. A. A. A. A. A. A. A. A. A				Day, Year)
			10	no (made	min))		3/13	6		J	ULY	11,	1005
	3		BR. A.	10.4	who completed cause of c	w 900	Туре,	Print) KILBR	2,00	ROA	Ba	2711	MORE	M	2005
ļ.;	Sta Registr		31. Date file	1 3 200	32. Registr	ar's Signature	di				,			,	

NJM	J44 <i>1</i> 9		1- State Unpend Item 23a&27 per me G846	epartment of Health and N Certificate of Death		ene . No. 200	p lung
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Harold E. Simmons		2. Date of Death Month July	2 2005	3.2mg/s/gag 2 1010 M
	Examir		4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview	4b. City, Town, or Location of Death Baltimore		4c. County of Dear Baltimor	
	, Funeral Director	l.	5. Social Security Number 112-20-2875 6. Sex 1 2 F 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) SEP 19,	ear) Co	thplace (State or Foreign ountry) YORK
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland Baltimore 10e. Street and Number	Dundalk	100	. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
	3a or 3	ם ו	1209 48th Street	21222	109	USA	Juliu y :
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar man be notified.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp. II Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within 72 hours ene. than "natural", in Medical Exp	Completed	(Specify only highest grade completed) [Gillier	acedent's Usual Occupation Give kind of work done during most of work (e. DO NOT use retired) Stock Person		Grocery	
Maryland 2	d 2 should be filed within the and Mental Hygiene. 7 Is marked other than "traumatic event, the Mer	To Be Co	17. Father's Name (First, Middle, Last) Samuel Simmons	18. Mother's Nam	e (First, Middle, Ma		
Aary	2 shot and N Is ma			lailing Address (Street and Number or Ru		•	
Baltimore, №	ages 1 and 2 ant of Health t: If Item 27 y or other tra		20a. Method of Disposition 1 Burial 2 **Coremation 3 Removal from State 20b. Place of Disposition 20b. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place O	crematory`or other place)	Date 20	c. Location - City or	Town, State
Baltir	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other		21. Signature of Funeral Service Licensee Edward A. Gregorchik	ematory, Inc. 7/8, 22. Name and Address of Facility Cremation Society 299 Frederick Road		Baltimore nc. ne. ND 212	
The state of the s	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Hypertensive Athe		or respiratory arrest		Approximate Interval Between Onset and Death
8760,	ate be executed Associate and	icai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). C. Due to (or as a consequence of). Due to (or as a consequence of).				
P.O. Box 68	ne death certification the attending plant is as the defended for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time ol death 9 ☐ Unknown	3 Dectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
	w requires that the been signed by should be detact		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		L.	o the cause of death?
II Reco	The taw re cate has bee page 2 sho	Completed			24a. Was an autopsy performe 1 Yes 2	prior to	utopsy findings available completion of cause of 2 \square
Division of Vital Records,	Attending Physician: Th r death. ector: After this certificate by the funeral director. pag	ation: To Be	25. Was case referred to medical examiner? 1 TYPes 2 No 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Accident investigation	atient 3 DOA Cther: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how	ce 6 Other (Spe	cify)
Divis	tal or Attendi s after death. al Director: A sd in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm building, etc. (Specify)	, street, lactory, office	281. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the desired physician in the des	or investigation, in my opinion, death occur			
	To the To the Comp	M	29b. Signature and title of certifier	29c. License number OCME		July, 8,	
			30. Name and address of person who completed cause of death (Item 23a) (Ty Ramelu E. Scothall, MD	111 Penn Stree			
4	Sta Registr	40	31. Date filed (Month, Day, Year) 32. Registar's Signature	Sparle			

		-	For State Registrar	State of Maryland			f Health a of Death	and Mer	ntal Hygiei Reg.	2001	22802
	Physicia	an	Decedent's Name (First, Middle, Last GEORGE ORMOND St						Date of Death Month	9ªy 8, 2¥85	3. Time of Death 0
	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number)	er	4b. City, Tow	m, or Location o	of Death		4c. County of Deat Ball	imore
	Funeral Director		213-05-0346	х 3 м 2 Б 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Y Months Da	ear If Under ays Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, Ye JULY 13	9. Bird 1917 Ma:	nplace (State or Foreign untry) ryland
	ryland how		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo						10d. Inside City Limits
	he Ma	ecto	Maryland Baltimor	re	Bal	timore	County		100	Citizen of What Co	1 Tyes 2 No
	with t	<u>-</u>	10e. Street and Number 213 Linhigh Aver	nue			21236		109.	USA	, .
36	be filed within 72 hours after death with the Maryland tial Hyglene. Id other than "natural", or fleme 23a or 28a-f show event, I're Medical Extribiner must be rediffed at	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 DYes 2 No If Yes, Give WW 11 Year or Dates:			of Hispanic Ori Cuban, Mexican		y Yes or No- an, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
15-0036	in 72 hour "naturel" ledical Ex	Completed by	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	tent's Usual O kind of work d DO NOT use re	one during most	t of working	166). Kind of Business/	Industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs.	Qualit	y Assura	nce Engir	neer	V	Vestingho	use
Maryland 2121	2 should be filed and Mental Hygis Is marked other surnatic event, II	To Be C	17. Father's Name (First, Middle, Last) William Andrew Sku	uhr			18. Mothe Lena	ers Name (F a Frie	irst, Middle, Maid da Gotts	den Surname) schalk	
Jan	2 sho		19a. Informant's Name/Relationship (T							ity or Town, State, 2	(ip Code)
Baltimore, N	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marks any njury or other traumatic RDCs.		Mary Jane Skuhr (V 20a. Method of Disposition ↑CXBurial 2 □ Cremation 3 □	Removal from State	ace of Dispo	sition (Name of matory or other	of r place)	Date	200	Md. 21236 Location - City or	
	it. Pa rtmen rtent: njury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Ligens			. Name and A	th Cem.	ty		ltimore,	Ma.
B	Dep any any		1 8. 7. Las	s show		Lassa 7401	hn Fune: Belair	ral Ho Rd. Ba	me Itimore	. Marylan	d 21236
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that ceused the death one cause on each line. a. END STAGE							Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ		RY DIS	EASE				
C.L.	uted d insit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence. ACUTE MYO		AL IN	FARCTI	ON			
3760,0	cate be executed oblysician and the burial-transit	icai Examiner	resulting in death) Last	Due to (or as a consequent	ence of):						
3	tificate ng phy as the		IE ECNAL C								
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9☐ Unknown	death 3	Ectopic pregr Other (special				23d. Date of del Month	ivery Day Year
۵.	quires that t n signed by uld be detai	þ	Part II. Other significant conditions co	ontributing to death but not resu	ılting in the u	nderlying caus	e given in Part I		23e. Did tobac	co use contribute to	the cause of death?
Records,	The law requir ate has been si page 2 should l	Completed							24a. Was an autopsy performed 1 ☐ Yes 24	24b. Were at prior to death?	utopsy findings available completion of cause of
Vital	Phyaician: The riths certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othor		Check only one)		
on of	ding F. After fune	tion: To	1 Yes 2 No 27. Manner of Teath 1 Natural 5 Pending investigation	28a. Sate of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Injury at Work?	280	5 [] Residence	e 6 Other (Spe injury occurred	cify)
Division of	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	ertification:	Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, st	reet, factory, o	ffice	28f	Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	e Hospital 24 hours a e Funeral l letely filled	edical C	29a. Certifier 10 Certifying Ph (Check only 2 Medicel Exemone)	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, deat tion and/or in	h occurred at i	he time, date ar my opinion, dea	nd place, and ath occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of dertifier	mehla	mo) 4141	21	29d.	Date signed Mont	h, Day, Year)
	10+1			completed cause of death (Item	23a) (Type,		DRIVE	TOWSO	N MARY	LAND	
	Sta Regist	ate rar	as Constituted (Manch Const Vans)	32. Registrars Signa 3 2005	turo						

			. 101	rtment of Health and Mental Hygiene tifficate of Death	894
			Decedent's Name (First, Middle, Last)		ne of Death
	Physicia /Medic		James B. Safranski	07 11 2005 12:	15 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death	
	Funeral	-	6603 Mt. Vista Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Kingsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (St. Country)	ate or Foreign
Е	Director		215–18–3854 ¹ ▼ M 2□F 82 Yrs.	11/01/1922 Marylar	
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	eation 10d. Insid	de City Limits
	e Man Imed	ctor	MD Baltimore Kingsvill	e ¹⁰	Yes 🏋 No
	with th	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	ns 23	Funerai	6603 Mt. Vista Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21087 U.S.A. /as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India Black, White, etc.	n,
٥	or Iter	/Fur	1 □ Never Married 2 📉 Married 1 📉 Yes 2 □ No	Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 📉 No Specify: ☐ Specify:	
315-UU36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I'm Medical Examinational by mailined at	ed by	3 Widowed 4 Divorced Year or Dates: WW TT	White ent's Usual Occupation 16b, Kind of Business/Industry	
ر ن	hin 72 3. In "na Medic	Completed	(Specify only highest grade completed) (Give life. L	ind of work done during most of working O NOT use retired)	
N	filed with Hygiene other the	Com	8 Iron	Worker Bridge Construc	tion
yland	uld be fill fental H rked oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	
	 Pages 1 and 2 should be diment of Health and Ments reant: If item 27 is marked njury or other traumatic e 	10		Agnes Parlinski g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
, mar	and 2 ealth a n 27 is			Mt. Vista Road - Kingsville, Maryland	21087
saltimore,	Pages 1 and nent of Health int: If item 27 iry or other t		1 Burial 2 MiCremation 3 Hemoval from State	atory or other place)	
	mit. Pa bartmen portant: / injury :a.			matory, Inc. 07/14/2005 Baltimore, Mary Name and Address of Facility E. F. Lassahn Funeral Ho	
ñ	permit Depar Impor any in	L	E. F. Landy 1		21087
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	Interva	imate I Between and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	not 4 m	ion lus
	Examiner		Due to (or as a consequence of):	•	
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last C		
20		icai E	d		
200	death certificate e attending phys od for use as the		IF FEMALE:		
XOR	leath certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day	Year
j.	that the deed by the detached	hysid	1 Yes 2 No 9 Unknown		
S, T	requires that the de been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the un		
cords,	law requires as been sign 2 should be	eted		1 Yes 2 No 3 Probably 4	
Zec	The law ate has I page 2 s	Completed		24a. Was an 24b. Were autopsy findi autopsy prior to completion performed?	of cause of
Vital	sician: The law certificate has t irector, page 2 s	O	25. Was case referred to medical	1 ☐ Yes No 1 ☐ Yes No 26. Place of Death (Check only one)	
0	hy Ithis	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		
	ling After fune	tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28d. Describe how injury occurred Work? M 1 Yes 2 No	
UIVISION	Attending or death. ector: After by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)	Number,
ב	ital or irs afte ral Dir lled in				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cau	se(s)
	within To the	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Yea	ar)
			My (MI)	DI848/ 7/11/05	
	1041		30. Name and address of person who completed cause of death (Item 23a) (Type, MYO TITAN 911M PHICAT	29c. License number DISY87 Printly ELPH(A ROAD, BACTO 2123	2
	Sta Registr	te ar	31. Date filed (Month, Pay Year) 3 2005	arli	
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			For State Registrar	State of Maryland	•	rtment of F			ene . no 2005	22805
	Physici		Decedent's Name (First, Middle, Last, VINCENT M. SPINOS					2. Date of Death Month	Day Year 9 2005	3. Time of Death 4:00 PM M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Dea	
			13301 Bottom Rd.			Hyde	es		Baltimo	re
	Funeral Director		215280000	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y,	ear) C	thplace (State or Foreign ountry) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Loc	eation				10d. Inside City Limits
	Mary P-feh	tor	MD Baltim	ore Hyd	des					1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number	•		10f. Zip Code		10g	. Citizen of What C	ountry?
	ath w	rai	13301 Bottom Road			21082			U.S.A.	
	er de Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ※ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi	
936	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2XNo	Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. dother then "netural", or Items 23e or 28e-f ehow event, The Medical Evariant must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occup	during most of work		b. Kind of Business	
121	within lene. then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	d)			_
d 2	filed v Hygie other 1		9 17. Father's Name (First, Middle, Last)	LA	Automo	tive Bod		er Repair ne (First, Middle, Mai		oloyed
lan	should be nd Mental marked o	To Be	Vincent Spinoso				Mary Sp	oargo		
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street		ral Route Number, C	ity or Town, State,	Zip Code)
d)	l and dealth om 27 her tr		Bernadette Spinoso 20a. Method of Disposition		1330	1 Pottom	Road - I	lydes. Mar	yland 2	1082
Baltimore,	permit. Pages of Department of Himportent: If ite any injury or ot ot others.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cem	netery, crem	atory or other place	1			
altin	nit. Partme orten injury		21. Signature of Funeral Service Licens	DC.	John 22.	Name and Addre	em. 107/1 ss of Facility E.	3/2005 _H F. Lassah	lydes, Mai in Filmera	cyland l Home, P.A.
ñ	Depa Impo any ii		· C. D. La	sanho				- Kingsvil		
	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. The cause on each line. Due to (or as a consequer	NCE	r the mode of dyin	ig, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	Examiner		Conversion to the searchine). ————————————————————————————————————	1100 017.					
	sit ad	iner	ir any, leading to immediate cause. Enter Underlying	Due to (o) as a consequen	nce oi).					
4	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):				-	
8760,	te be e ysician ie buris	icai E	L.	1						
9	tificate ng phy as the	ed		·						
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	s that med b e deta	by Pt	Part II. Other significant conditions cor	ntributing to death but not resulting	ng in the un	derlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	ted t	CORDNARY N	RIERY DISBY	ZR_			1 Yes	2 □ No 3 □ P	robably 4 Unknown
Records,	0 5 0	Completed						24a. Was an autopsy performed 1 ☐ Yes 2X	prior to death?	utopsy findings available completion of cause of
	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					th (Check only one)		
of <	this aldi	ဥ	1 ☐ Yes 2 🔀 yo	· · · · · · · · · · · · · · · · · · ·	VOutpatient		4 Nulsing Fit		e 6 ☐Other (Spe	cify)
	Jing After fune	tlon	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
=	or Atten frer deat directors in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location (Stree City or Town, S		ural Route Number,
_	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the tin	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	0.50.1		29c. License	-	29d.	Date signed (Mont	h, Day, Year)
)	7		1 Christoper	4. 15 to, M		034	1249	7	11/2005	
	30		30. Name and address of person who co	ompleted gause of death (Item 23	3a) (Type, F	Print)	1271			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrat's Signature	e L	T. IND L	1200			
	Registr	-	JUL 1	3 2005 Seems	المساكلي و	No State of the St				

			1 - For State Registrar 1. Decedent's Name (First, Middle, Las	State of Marylar		artment rtificate					Reg. No.	2005	12.2.2.0.6
	Physici /Medio	cal	LLYOD	SHINSATU		45 Ct. T				Month 07	Day	Year 2005 County of Death	02:201M
	Examir	ier	110 0000 01	ounty Elen.	-		Co	Location of lumb	وردر			Howa	
	Funeral Director		373-00-4040		1ast birthday) 53 Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day July 19	h v, Year) • .195	9. Birth Cou 1 Hawa	place (State or Foreign ntry) 11
	Aaryland I show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim		ty, Town or Lo	ocation	0						10d. Inside City Limits 1 ☐ Yes 2X No
	or 28a-1	Funeral Director	10e. Street and Number	ore	Cator	10f. Zip (10g. Citiz	en of What Cou	ntry?
	ath w	ral	615 Woodhurst W	-				228				.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show amy injury or other traumatic event, Ite Maralcal Examination in all find at anging.	by Fune	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:		was Decede If Yes, speci 1 Tes 2		spanic Orig n, Mexican, Specify:	in? (Spec , Puerto R	ify Yes <i>o</i> r No- ican, etc.)		4. Race - Ameri Black, White, Specify: Jaj	
9500-61212	thin 72 ho e. an "natur Modical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	dent's Usual kind of work DO NOT use	done d retired)	uring most		g	16b. Kin	d of Business/Ir	ndustry
	led wi tygien har th nt, ILe	S	17. Father's Name (First, Middle, Last)	3	Voi	ce In				(First, Middle,		Army	
anc	d be fi ental h ked ot c evel	To Be	Yoshinobu Shinsat	0					aye A		WAIGE!! C	ourname)	
Maryland	12 should be filed within "n and Mental Hygiene." Fis marked other than "rearmatic event, It a Men	-	19a. Informant's Name/Relationship (7	Type, Print)		•		nd Number	r or Rural	Route Numbe		Town, State, Zij	
	is 1 and 2 of Health ar item 27 is other trac		Rosaleen F. Shins 20a. Method of Disposition	20b.	Place of Dispo	sition (Name	e of	-1	Cato	-		aryland ation - City or T	21228 own, State
jo E	Pages ent of lat: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	natory or oth	her place	· 1	7-12-	2005		≘1, Mary	
Baltimore,	permit. Departm Importal any inju		21. Signature of Funeral Service Licen	h se	Wi 16	Name and tzke 30 Ed	Address Fune	ral H	Home	of Cat	onsv: svil	ille, In	nc.
	Pnysician /Medical		23a. Part 1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the dea one cause on each line.				, such as o		respiratory ar	rest,		Approximate Interval Between Onset and Death
8/60, /	The law requires that the death certificate be executed to the heas been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	quence of):				-				
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	w requires that to be the signed by should be detailed.	by	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying ca	use give	n in Part I.			bacco us	/	he cause of death?
l Heco	The law re ate has bee page 2 sho	Completed			·····					24a. Was autop perfor 1 Yes	sy	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
/Ita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho			Check only o			
Division of Vital Records,	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		c. Injury Work		28	e 5 🗌 Resid 3d. Describe h		Other (Special occurred	(y)
DIVISI	al or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined		ome, farm, str fy)	eet, factory,	office		28	Bf. Location (S City or Tow	itreet and n, State)	Number or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurred a	t the time	e, date and inion, death	f place, an	d due to the d	ause(s) a fate and p	ind manner as s place, and due to	tated. o the cause(s)
	To the within 2 Fo ths comple	Med	29b. Signature and title of certifier			29c.	License	number	-	2	29d. Date	signed (Month,	Day, Year)
			Vaun-				Do	o 53	709		7	7/7/0	5
	20		30. Name and address of person who o	completed cause of death (Iter	m 23a) (Type, Lallav	Print)	cryc	ST	E 2	-10	130m	ie m	1) 20715
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	St 19	bere	Co					

			1 - For Stata Registrar	State of Mar		artment <i>rtificate</i>			and M		iene	35	22897		
п	Physic	ian	Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Year	3. Time of Death		
	/Medi	cal	Richard James Sch							July		2005	10:06 AM		
7	Exami	ner	4a. Facility Name (If not institution, give s 4. Aanes Hea	itreet and number) IHCAPE	,	4b. City, To		ocation o		,	4c. Count	y of Death			
	Funeral		Social Security Number 6. Sex		In yrs. last birthday)	If Under 1		If Under a	_	8. Date of Birth		9 Rirtho	ace (State or Foreign		
В	Director		216-66-2596	[M 2□F 4]		Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Sept. 23	Year) 1963	Mary	try)		
	and *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	eation									
	Marylan f show	ō	Maryland Baltimor		Catonsvi							10	0d. Inside City Limits 1 ☐ Yes 2 📉 No		
	death with the Maryland ms 23a or 28e-f show	Director	10e. Street and Number		Catolisv	10f. Zip C	ode			1	0g. Citizen of	What Cours			
	h with		466 Kent Avenue				2122	ρ		L'		Wilat Couli	пут		
	ems :	Funeral	11. Marital Status	Was Decedent Ever Armed Forces?	er in U.S. 13.				gin? (Spe	cify Yes or No- Rican, etc.)		ce - America			
36	s after	by Fu	1 Never Married 2 X Married	1 ☐ Yes 2 ☐XNo If Yes, Give	ľ	1 ☐ Yes 2	_	Specify:	, Puerto i	rican, etc.)		ck, White, e v: Whi			
Maryland 21215-0036	72 hours after natural', or Ite	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual									
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work DO NOT use	done dui retired)	ring most	of workir	ng	16b. Kind of B	usiness/Ind	ustry		
21,	d with	mo.	Elementary/Secondary (0°12)	College (1-4or 5+)	Self E	mplove	ed				Constr	uctio	n.		
pu	be filed tal Hygi d other avent, t	Be (17. Father's Name (First, Middle, Last)				1	8. Mother	r's Name	(First, Middle, M	Maiden Surnai	ne)			
<u>y</u>	should Ind Men	ို	Robert Schwaab							Barron					
Mar	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type Barbara Schwaab	•						l Route Number,					
	1 and Healt am 2		20a. Method of Disposition	Wi	20b. Place of Dispo	sition (Name	of	ie; C		sville,	Mary 1.				
JO.	Pages nent of nt; If it,		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crer	natory`or othe	er place)	·v 7							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important; If itam 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic avent, if a Medical Examiner must be netitived at once.	Balto.Wash.Crematory 2						of Facility	n Sc	13/2005 Laurel, Maryland 1 Schwab Funeral Home, Inc. 1 Schwab Funeral Home, Inc. 1 Schwab Funeral Home, Inc. 1 Schwab Funeral Home, Inc.					
			23a. Part 1. Enter the disease, or complice	ations that caused the		/30 Ed	DITOILL	ison	Ave.	Catons	ville.	MD 21	.228		
	Pnysician	3	Immediate Cause (Final	e cause on each line.									Approximate Interval Between Onset and Death		
4	/Medical		disease or condition resulting in death)	Due to (or wa c	onsequence of):	Nelc	(VIC	MO	c M	etas te	atic	(omo		
	Examiner		Cognostially list conditions h		, , , , , , , , , , , , , , , , , , , ,										
1	יו ע	iner	Sequentially list conditions, any, team of the mediate cause. Enter Underlying Cause (Disease or injury	Dusito (snacia e	onsequence of):										
V	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a co											
8760,	ate be ex hysician the buria	a E		Due 10 (01 as a ci	onsequence or).										
687	ificate p phys as the	edical	d.												
Вох	eath certific attending p for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of p		F					23d. Da	e of deliven	,		
	ed for	sicle	in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ 4 Pregnant at tim 9 Unknown		Ectopic preg Other (speci					Мо		yay Year		
P.0	that the de ed by the a detached	Phy	9 🗆 Unknown												
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3ec	e faw r has be ge 2 sh	Completed								24a. Was an autopsy		rior to comp	sy findings available pletion of cause of		
		e Co	75 Mag constant to the live								XNo 1	leath?	□ No		
Vital	Physician: this certificated director, i	0 B	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	spital: 1 Inpatient	2 ER/Outpatient		0.1			(Check only one		17137	_		
J of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye			Injury at Work?			e 5 Resider					
ior	Attanding I death. ctor: After y the funer	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	nar) Injury	М		2 □ No	0						
Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	et, factory, or	ffice		28	3f. Location (Stre City or Town,	et and Numb State)	er or Rural I	Route Number,		
	To the Hospitel or I within 24 hours after To the Funeral Director Completely filled in b	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Exemine	cian: To the best of m or: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred at t estigation, in	he time, my opini	date and on, death	place, an	nd due to the cau d at the time, dat	ise(s) and ma e and place, a	nner as stat ind due to th	ed. ne cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Li	cense nu	ımber		296	d. Date signed	(Month, Da	ıy, Year)		
)			DI A	$\wedge \wedge \wedge$	\cap	Di	3.50	154		-	1-7.	OF			
	/		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type, F	1						3			
	u		Chole Miller	WO 90	DS, Co	Dough	ine	101	1171	morle	M	100	129.		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's :	Signature	1 . 1	3								
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Richard J. Schwaab

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>005</u> **Physician** Year Milton G. Smith, Jr. July 4:30 a M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2817 Armacost Road Finksburg Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F Months Days Hours Min. Yrs. 65 Director 214-36-8870 July 25. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heatih and Mental Hygiene. Then to the firem 27 Is marked other than "natural", or Itams 23a or 28a-1 show ury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2X No MD Carrol1 Finksburg Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 Armacost Road 21048 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korean 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice President G & L Fabrications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) G. Smith, Sr. Milton Mildred Litsinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine M. Smith Wife 2817 Armacost Road Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State parmit. Page Department (Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser. 7/13/06 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 Turs-Les 23a. Pant . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the chine. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 nding physician The law requires that the death certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à certificate has been signad lirector, page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this After th 28d. escribe how injury occurred 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No **Director:** 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

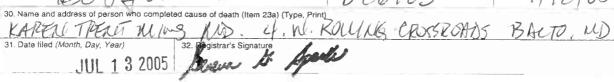
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and Itle of centric 29d. Date signed (Month, Day, Year) 30. Name and (Item 23a) (Type, Print) 0d MIG 0 31. Date filed (Month, Daly, Year) Registrar's Signature State 1 3 2005 Registrar

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Jennetta Thompson Baltimore, Maryland 21215-0036 Division of Vital Records P.O. Box 68760

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Physici /Medio		JENNET	A A.	THOM	RSON.	JULY ,	Day Year 2005	12:30P.M
Examir	er	4a. Facility Name (If not institution, give		4b. City, Town,	or Location of Death	/	4c. County of Death	
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Director		218-28-8845	M 21XF	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	1934 NOR	place (State or Foreign htry) TH CAROLIN
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72 hc	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retir	ipation a during most of worki	ng 16t	o. Kind of Business/In	dustry
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		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused the death, e cause on each line.	Do not enter the mode of dy	ring, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	derotec	adjova	Sculer	-discise	/
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ath cer ttendir or use	Physician/Medical	230. was decedent pregnant	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of		су		23d. Date of delive	
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Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	- (0	26. Place of Death			
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or Hospital or Attanding Physician: The law requires that the death certificate be exin 24 hours after death. 24 hours after death. The law requires that this certificate has been signed by the attending physician and the law in the funeral director, page 2 should be detached for use as the burial	0	29a. Certifier 1 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death occurred at the ton and/or investigation, in my	ime, date and place, a opinion, death occurre	nd due to the cause od at the time, date	o(s) and manner as sta and place, and due to	ated. the cause(s)
To the Hospital or Attandi within 24 hours atter death. To tha Euneral Director: A completely filled in by the fu	Medical Cer	(Check only 2 Medical Examin	er: On the basis of examination	on and/or investigation, in my 29c. Licen	ime, date and place, a opinion, death occurre se number	d at the time, date	o(s) and manner as stand place, and due to Date signed (Month, L	the cause(s)

State Registrar



State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 8 per fh G845 7-22 Of title ate of Death Reg. No 2 0 0 . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year :15 PM Maurice Bernard 2005 Thomas JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES baltimore Healthcare If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8-13-691968 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 35 Yrs Director 217-84-5108 Md. Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director M☐Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 501 Linwood Avenue 21205 USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. In 27 Is marked other than "naturel", or Iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Varies 12 grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rudolph Williams ပ Bernadette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is eny injury or other tra <u>once.</u> Bernadette Thomas Mother 130 Shady Tree Lane, Raeford, N.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Johnson Family Cem. 7-15-05 Raeford, N.C. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONTA **Physician** 2 WEFIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Ulsease of Injury] Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/1 No certificate 1 Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 X No 1 npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. DO061765 JULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILKENS AVE #307 BALTIMORE MUS 21229 QUATHED EBEPT 2FIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Filmen D. Gyster ORIGINAL

DHMH 17 Rev 1/2001

MAUSICE

HOMAS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year **Physician** uzerls July)or othy 2005 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Woodlawn

If Under 24 Hrs.
Hours Min.
B. Date of Birth
(Month, Day, Year)
Dec 24, 1925

Exmure, Va. Jonny Cake Rd If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1□M 2**)** F Months Days Yrs. 219-14-0516 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or items 23s or 28s-f show Baltimore MD 1 No Director Bartimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bonner USA 4212 Rd 21216 Pagas 1 and 2 should be filed within 72 hours efter death value of Health and Mantel Hyglene.
Int: if Item 27 is marked other than "naturel", or Itema 23aury or other treumatic event, the Medical Examiner man Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 21215-0020 2 Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) vod Service Food 124 Technician Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph Sheppard Buzabeth Veney 19a. Informant's Nam elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Balto, my 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Deborah A. Taylor 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Woodlawn Cometic Jul 13, 3 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald Bitsnupen Funeral Home mald Balti ma 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) by Physician/Medical Examiner yperter sion or Attending Physicisn: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, rabetes Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 20 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was an autopsy performed? After this certificate has 2 E No 1□Yas 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicism: within 24 hours after deeth.

To the Funersi Director: After this certifica completely illied in by the funerel director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EPFOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-12-05 D46444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST BALTIMORE MD EVERETT, MD 2323 ORLEANS 21224 VINA 31. Date filed (Mo L 1 3 2005 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CLARA 5 AMOHT JULY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner llstown If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F 9 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or itame 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at Nood 1 Yes 2 No Director IT, MOITE 10g. Citizen of What Country? **voa** by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Importent: if teem 27 is marked other than "natural", or ital any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 1 Baltimore, Maryland 21215-0036 Specify: Blac 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working the DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry /Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Name (First Middle, Last) 20a. Method of Disposition

1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition Sign ture of Funeral Service Lit ensee Istown 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coli /Medical Examiner URENARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Metafalil Encephalopathe 1 Yes 2 No 3 Probably 4 Unknown Cecal CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed HTW 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a To the Funeret L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D44201 8,2005 o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 3 2005

IMPERIAL, Jn.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 [] 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DEROTHA C. TURNER 07.08.2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner STELLA MARIS BALTIMORE 1 IMONIUM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08.30.1943 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 215.40.7466 Yrs **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits "neturet', or Items 23a or 28a-f show injury or other treumatic event, the Madical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No Director MD CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2621 HALLAM Court 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmetin. College (1-4or 5+)

6 YRS Elementary/Secondary (0-12) 121H GRADE COMPUTER ANALYST NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES ELUSON VERNELL COUNTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (MOTHER 3101 CLIFTON AVE. BALTIMORE , MD VERNELL BYNUM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS 07-13-05 BALTIMORE 4 □ Donation 5 □ Other (Specify) 21. Signative of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD 21229 Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER LUNG /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Describer 1997) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 □ No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) FURNER, examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 24 hours after death. 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aft To the Funeral D completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dulaney Valley RD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmooa Timonium, MD 31. Date filed (Month, Day, Y 32. Registar's Signature State JUL 1 3 2005

DHMH 17 Rev 1/2001

Registrar

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1 10	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of De	ath	C 0 (Year	5. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give st ROSEWOOD STATE HO				⁴b₩ĭ	NGS 1		Death	JULY			of Death MORE	0620 A ^M
9	Funeral Director		5. Social Security Number 214-92-8563 %		(In yrs. las 46	t birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da JAN 25	th ay, Year) 19	59 J	9. Birthp Coun Mary	
7	aryland show	7	Usual Residence of Decedent 10a. State 10b. County		10c. City,									1	0d. Inside City Limits
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant and must be notified at once.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Tyes 2X N If Yes, Give Year or Dates:	ever in U.S.	1	Vas Dece Yes, spe Dece		spanic Orig n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No Rican, etc.)	0-		k, White,	an Indian, etc. White
21215-0036	within 72 ho ane. than "natur se Medical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5		16a. Deced (Give life. L Neve	kind of w OO NOT i	ork done d ise retired	lurina most	of workin	g		ind of Bu	siness/Ind	dustry
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	ind 2 shore alth and N 27 is ma		19a. Informant's Name/Relationship (Type Frederick Grandon	Traut, J	r.	19b. Mailin 1309	g Addres Loci	s (Street a 1St A	venue	r or Rural Be	Route Numb	рө <i>г, City</i> о	2101	State, Zip 4	Code)
Baltimore,	Pages 1 and of He out: If item ary or other		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. July 7,2005 Baltimore,												
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<u>α</u>	wrequires thet the de been signed by the s should be detached t	ed by Pr	Part II. Dther significant conditions confi Down [†]s Syndrome	tnbuting to death bu	ut not resulti	ing in the u	nderlying	cause givi	en in Part I.			tobacco (ibute to th	ne cause of death?
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Division	Attending I ar death.	27. Nagner of Death 1 A Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Injury M 28b. Time of Injury at Work? Injury M 1 Yes 2 No 28b. Date of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred							I Route Number,						
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0.	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	r's Signatu	TO S.	GO	A COLO							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Year **Physician** Turnbull Ada Trene 2005 July 9 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ivy Hall Geriatric & Rehab. Ctr. Middle River Baltimore Co. 8. Date of Birth (Month, Day, Year) April 16,1908 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 □ M 2 🖾 F 97 Maryland Director 213-10-6748 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "naturel", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Middle River Marvland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 21220 United States 1510 Dornton Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ant: if item 27 is marked other than "naturet", or its ury or other traumatic event, the Medical Exprine 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Typist 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mollie L. Grey George Henry Degenhard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health er Important: If item 27 is eny injury or other trau 1510 Dornton Ave. Middle River, MD Mr. David T. Turnbull (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed and Box 68760 attending physician Physician/Medical as the IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 1 the detached 9 Unknown ፭ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 1 Yes 2 No 3 Probably 4 Wiknown Completed page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has 2 No 1 Yes ospital or Attending Physician: hours after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be Hospital: 1 Inpatient P Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injusy Matural 5 Pending 1 🔲 Yes 2 No investigation 2 Accident Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21222 2 Market Place Savinder K. Julka, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 Registrar

			1 - For State Registrer	State of Marylar	nd / Depa		lealth and	Mental Hygi	•	E 2002
	Physici /Medic		Decedent's Name (First, Middle, Las MITZI	t)		SELL0		2. Date of Death Month	Day Yea	05 12:45 P.M
	Examir Funeral	er	4a. Facility Name (If not institution, give UNION MEMORIAL 5. Social Security Number 6. Se	HOSPITAL 7. Age (In yrs.	, .	4b. City, Town, o	BALTIMO If Under 24 Hrs. Hours Min.)RE	4c. County of De	N/A sirthplace (State or Foreign
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	ith the Mary or 28a-f sh	Olrector	MD N/A 10e. Street and Number		BALT	IMORE 10f. Zip Code		104	g. Citizen of What	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, the Medical Evaluation rules for notified at once.	y Funeral Director	2434 W. BELVEDES 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	21215 dispanic Origin? (San, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi	USA merican Indian, hite, etc. WHITE
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Baltimore,	permit. Pages Department of I Important; If its any injury or o		1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. September 1 Service Licen		_TIMORE	HEBREW Name and Addre	CEM. 07/	OL LEVINS	ON & BROS	ORE, MD ., INC. ., MD 21208
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Division	Hospital or Attanding I 24 hours after death. Funaral Diractor: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specif	fy)			City or Town,	State)	Rural Route Number,
	To tha Hospital or within 24 hours afte To tha Funaral Dirr completely filled in I	Medical	29a. Certifier (Check only one) 2 Medical Exam 29b. Signature and title of certifier	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or in	o occurred at the tirvestigation, in my o	pinion, death occu	rred at the time, date	se(s) and manner a and place, and di 	ue to the cause(s)
•	⊢s⊢ŏ		30. Name and address of person who c	completed cause of death (Iter	79 D n 23a) (Type,		7/23	5	TULY C	8,05
	Sta Registr		30. Name and address of person who control of the state o	32. Rejistrar's Signa	ature A	partie	aniv.	TRIVE	BALTI	2126

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Baltimore, Maryland 21215-0036

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Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify)	20b. Place of cemetery	v, crematory o	r other p LN 4	TORY //14	1105	BAlto M	٥.
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of	Phys r this aral di	. To	27. Manner of Death	28a. Date of In	iury	28b. Time o	f 28c. Inju	ury at	Nursing ric	28d. Describe			city)
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	10		Julie Losm	ian Mb	49	40	Print) AF.	Ave	1	Sallinor	L,M	0 6	1/224
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WATSON SR., CHARLES

		1 - For State Registrar	State	of Maryland		artment : <i>rtificate</i>					-			
	-	Decedent's Name (First, Middle	, Last)			tineate	01 1	Call	1	2. Date of Dea	Reg. No.	200	15 3. f	ine of Death
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/Med Exam		4a. Facility Name (If not institution,	give street and no			4b. City, To	own, or l	Location	of Death	- (4c. C	ounty of De		
9	м	GOOD SAMAR	ITAN	HOSPIT	AL	'BA	LT	IMO	RE			NA	1	
Funera		5. Social Security Number	6. Sex 1√□M 2□F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	y, Year)	9. B		State or Foreign
Directo		218-01-1989 Usual Residence of Decedent		89						7-2-1	6			Md.
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72 hours after dea "natural", or Items	Completed	15. Decedent (Specify only highes)	(Give	dent's Usual (done du	uring mos	t of workir	ng	16b. Kind	of Busines	s/Industry	
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2 should be filed within and Mental Hygiene. Is marked other than surmatic event, It e M.		10th grade 17. Father's Name (First, Middle, L	_ast)		Mac	chinist		18. Mothe	er's Name	(First, Middle,			Box	Factory
ld be ental ked o	To Be	Robert		W:	atson				Maggi			owler		
should nd Men marke umatic	-	19a. Informant's Name/Relationsh	nip (Type, Print)	***		ng Address (5	Street ar			l Route Numbe				
and 2 salth a n 27 is	1	Richard Watson	s So	n	2309) H Fa	all	Gabl	e Lar	ne, Bal	timor	e, Md	. 21	209
es 1 and 2 of Health of Item 27 i		20a. Method of Disposition			ace of Dispo	osition (Name matory or other	of	-		ate		ation - City o		ate
permit. Pages Department of Important: If i any injury or once.		1 Burial 2 □ Cremation 1 Other (Sp		1 State		em. Par		1	713-	-05	Rand	lallst	own,	Md.
permit. Departn Imports any inju		21. Signature of Funeral Service L	icensee			2. Name and		s of Facili	ty	Balti			2120	
80 5 8 6		> Carriel	e in		1	March E	F.H.	Eas	t	1101 E	. Nor	th Av	e.	
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on	caused the death.	Do not ent	ter the mode of	of dying	, such as	cardiac o	r respiratory ar	rest,		Interv	oximate al Between
Physician	_	Immediate Cause (Final disease or condition	_ 3E	PTIL S	SHOCK	<							Onset	t and Death
/Medica Examiner	_	resulting in death)	Due to	o (or as a conseque	ence of):									
		Sequentially list conditions, if any, leading to immediate	U	OEUMO (or as a conseque										
nsit	Examiner	Cause (Disease or injury	111			- 1115	y-6-	TIAA						
executed n and ial-transit	xar	that initiated events resulting in death) Last	c. Due to	CIMARY (or as a conseque		INF	EC	LLON	,			_		
e be sicial	_		d											
g phy as th	edi													
death certificate be e attending physicia of for use as the bur	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregnan	icy	Ectopic pred					230	d. Date of d	elivery	
w requires that the death certificate be upone signed by the attending physicial should be detached for use as the buri	Physician/Medical	in the past 12 months?		nant at time of dea		Other (spec		-				Month	Day	Year
at the	Phy	9 Unknown												
res th igner		Part II. Dther significant conditio							•			contribute		
law requires that the as been signed by th 2 should be detache	eted	HYPERTENSION	•					,		101	′es 2 🛂	No 3∐I	Probably	4 Unknown
has e 2	Completed by	CORONARY ARTE		-						24a. Was autop	SV	prior to	o completion	dings available n of cause of
That at a page		INSUFFICIENCY,	CHRONIC	- OBSTRU	CTIVE	PULMO	NAR	ZY I	ISEAS	€ 1 ☐ Yes	2 No	death? 1 ☐ Ye	s 2 No	0
	Be	25. Was case referred to medi I examiner?	Hospital:	/			Othor	P*		(Check only o				
cert	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a Date	Inpatient 2 E	R/Outpatier 28b. Time o			4 (1)		ne 5 Resid			ecify)	
Physicia r this cert ral directo	6	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		of Injury nth, Day Year)	Injury	м 200	: Injury : Work? 1 □ Y	? es 2 □		.ou. Describe n	iow injury c	occurred		
ding Phys	=	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury - At hor	ne, farm, str					8f. Location (S	Street and I	Number or F	Rural Route	Number.
ding Phys	ficati	4 Homicide determi	build	ding, etc. (Specify)						City or Ton	m, State)			
ding Phys	Sertificati			a bast of my know	rledge, deat	h occurred at	the time	e, date an	d place, a	and due to the o	cause(s) ar	nd manner a	as stated.	wen(s)
ding Phys	ical Certification:	29a. Certifier 1 Certifying	g Physician: To the	basis of examination	on and/or in									
ding Phys		29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	basis of examination	on and/or in									
Attending Physr death. sctor: After this by the funeral di	Medicai Certificati	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	basis of examination	on and/or in			number	00			signed (Mor		
ding Phys		29a. Certifier 1 Certifying (Check only 2 Medical E one) 29b. Signature and Little of certifier	and mai	basis of examination of stated.	on and/or in	29c. L	License PG	number	20					
ding Phys		29a. Certifier 1 Certifying (Check only 2 Medical E	and mai	Dasis of examination of the state of death (Item)	on and/or in	29c. L	License LG Amy N	number OC	20 y MD		29d. Date :			

State of Maryland / Department of Health and Mental Hygiene

		Certificate o	1109.110.
	Physician	Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Day Year 3. Tole of Death
4	/Medica	Burton E. wheeler, Sr.	07 03 05 6:26P.M.
أمر	Examine		4b. City, Town, or Location of Deeth 4c. County of Death
		Manor Care Chevy Chase	Chevy Chase Montgomery
	uneral irector	5. Social Security Number 577-12-2187 6. Sex 123 M 2 F 88 7. Age (In yrs. last birthday) If Under 1 Yea	
ylend	show det	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Mag	28a-f sl	D.C. Washington	1 Mg Yes 2 □ No
t t	or 28	10e. Street end Number 10f. Zip Code	10g. Citizen of Whet Country?
<u>*</u>	23a C	657 Girard Street N.E.	0017
deat	E 5	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of	0017 IJSA f Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc.
1215-0020 within 72 hours after death with tha Maryland	al, or items 23a or 28a-fsi Examiner must be notified by Europeal Discolory	Armed Forces? If Yes, specify Control of the second of the	uban, Mexican, Puerto Rican, etc.) Black, White, etc.
Maryland 21215-0020 td 2 should be filed within 72 hours af tth end Mantal Hydiene.	of the Medical	15. Decedent's Educetion 16e. Decedent's Usual Occ (Give kind of work don (life DO NOT) use paties.	supetion 16b. Kind of Business/Industry red) 16b. Kind of Business/Industry 16b.
d 212 filed with	than than	Elementary/Secondary (0-12) College (1-4or 5+) Construction,	/Blue Print Supv. U.S. Government
E SE	= -	17. Father's Name (First, Middle, Last) Clifford Wheeler	18. Mother's Name (First, Middle, Maiden Sumame)
Aarylan 2 should be 1 end Mantal	T affe	oritioid wheelel	Clara Simms
a sk s	item 27 is marka other traumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	et and Number or Rural Route Number, City or Town, State, Zip Code)
≥ end		Carolyn W. Landry/Daughter 25085 Lechan	ne Rd. Delisle, Ms. 39571
Baltimore, bemit. Pages 1 er	mportant: If Item 27 any injury or other to ance.	20a. Method of Disposition 20b. Place of Disposition (Name of	Data Chartier City of Town Chate
MOI Pages ant of	ry or	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HArmony Memorial	
Balti permit. P	important: any injury once.	21. Signature of Funeral Service Licensee 22. Name and Add	
~	any i	A R manhall 4217 9th.	St. N.W. Washington, D.C. 20011
4		23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dishlock, or heart failure. List only one cause on each line.	ying, such as cardiac or respiratory arrest, Approximate Interval Between
	sician		Onset and Death
	edical	Immediate Ceuse (Final disease or condition Dysphagia	
EXa	miner	resulting in death) Due to (or as a consequence of):	
T		Aspiration Pneumonia	
cute	ing physician and e es the bunal-trensit	Sequentially list conditions. Due to (or as a consequence of):	
o, 🖁	an a Linari	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Domesti
68760, lificate be axe	ysici ye bu	Cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Dementia
86 g		resulting in death) Last	
Box			
	d for atte	Part II Other electificant en dist	
P.O.	ied by the attend detached for us Y Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	77
E E	deta V		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Records, P.O. Box 68760, aidian: The law requires thet the death certificate be assocuted	been signed I should be det leted by P		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
Rec	has ya 2		1 Yes 2 No 1 Yes 2 No
	certificata rector, pag	25. Was cese referred to medical	26. Place of Death (Check only one)
of Vita	= 0	1 Yes 2 No Hospital:	ther: 4 Nursing Home 5 Residence 6 Other (Specify)
P P	£ 78	The state of the s	4 Nursing Hone 5 Linesidence 6 Liother (Specify)
₽ ♣ ₹	for the	1 StNaturel 5 □ Pending (Month, Day Year) Injury Wo	ork? □ Yes 2 □ No
Division or Attending after death.	at Director: After tad in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	
affer D	ert in the	4 Homicide building, etc. (Specify)	City or Town, State)
pital	fill ac		ing data and place and dura to the
To the Hospital within 24 hours	To the Funeral Director: After completely filled in by the funer Medical Certification:	(Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	opinion, death occurred at the time, date and place, and due to the cause(s)
of the	omple Me		ise number 29d. Date signed (Month, Day, Year)
7	-°//	1 mm	
	//	00 Normandada (July 7, 2005
*	>	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Susan Miller, MD. 8700 Jones Mill Ro	d. Chevy Chase, MD. 20815
F	State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signature	

			1 = For State Registrar		ryland / Dep		Health and M Death	lental Hyg	_	5 22913
	Physici /Medio Examin	al	4a. Facility Name (If not institution, give s				or Location of Death	2. Date of Deat Month July	7, 2005 4c. County of Dee	
	Funeral Director		210-01-0903		(In yrs. last birthday		timore r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, MOTCh 22	Baltime 2,1914 Ma	THE thplace (State or Foreign buntry) LYLANA
	within 72 hours after death with the Maryland one one than "natural", or liems 23e or 28e-1 show than "he Medical Exemine must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon 10e. Street and Number	e	10c. City, Town or L	ocation altimore 10f. Zip Code		1	Og. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
	er death with tems 23a or	by Funeral Di		2. Was Decedent E Armed Forces?	ever in U.S. 13.		21234 Hispanic Origin? (Spiban, Mexican, Puerto		U.S.A. 14. Race - Ame	erican Indian,
21215-0036	72 hours after death with the Manylan naturst', or items 23a or 28a-1 show idipal Examiner must be multiad at	eted by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 🐴 N If Yes, Give Year or Dates:	16a Dece	1 Yes 2 No		ing	Specify: W	
	Hygi Hygi other	Be Completed	Elementary/Secondary (0-12) 8th Grade 17. Father's Name (First, Middle, Last)	College (1-4or 5	+) life.	DO NOT use retir Machini			Manufactw Maiden Sumame)	ring
Maryland	s 1 and 2 should be Health and Mental Item 27 is marked o other traumatic sv	ToE	Ira Wilson 19a. Informant's Name/Relationship (Typ. Deborah Wilson (Da						, City or Town, State,	
Baltimore,	90=5		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Ro 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disp cometery, cre Parkwood	osition (Name of or other pl Cemetery	(ace) 7/12	/2005 B	20c. Location - City or altimore,	Town, State Maryland
■ Balt	permit. Pag Depentment Important: any njury once.		21. Signature of uneral Service Trense	3		9705 Beli	altimore		Approximate	
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		0 RU1	VAN-1	Anten	(1 1	12 EATE	Interval Between Onset and Death
760,	eath certificate be executed attending physicien and for use as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):		L MUZ	,		2000
O. Box 68	The law requires that the death certificate tte has been signed by the attending phy agge 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of de Month	livery Day Year
ords, P.	w requires that been signed should be del	by	Part II. Other significant conditions con	tributing to death bu	nt not resulting in the	underlying cause g	iven in Part I.	23e. Did tot	s 2 No 3 P	o the cause of death?
of Vital Records,		e Completed	25. Was case referred to medical					24a. Was a autops perform	y prior to ned? death? 2 No 1 □ Yes	utopsy findings available completion of cause of
	S 20	ToB	examiner?	ospital: 1 Inpatier 28a. Date of Injur (Month, Day	v 28b. Time		ence 6 Other (Spe	cify)		
Division	To the Hospitel or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home, larm, s . (Specify)	treet, lactory, office	9	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	the Hosp ithin 24 hour the Funer empletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination and/or is	nvestigation, in my	time, date and place, opinion, death occurr	ed at the time, da	ause(s) and manner as ate and place, and due 9d. Date signed (Mont	e to the cause(s)
-6			30_Name and address of person who con	mpleted cause of de	Q Q W W ath I m 23a) (Type)	48025		7-8-	05
1	Sta		Soltal (Month, Day, Year)	RN(M)	r's Signature	1/55/5	2 /hre	, 212	237	
	Registr	ar	iin 1 2	2005	and M	formal !				

ORIGINAL

			-	State of Maryland /		rtment of H			_	
		•	For State Registrar	otato ot marytana,	-	tificate of L			No.2005	22914
I	Physicia /Medic		1. Decedent's Name (First, Middle, Las	Ward				2. Date of Death Month	Day Yeer () 200	
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death	1	4c. County of Dea	
			5. Social Security Number 6. Se	an HOSPItal	hirthday)	Isahim	If Under 24 Hrs.	8 Date of Birth	N/A	rthplace (State or Foreign
	Funeral Director			M 201 65	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 2-20-/9		country) and
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
	Maryi -f sho	tor	led N/A	0	1'mo					1 ⊠Yes 2 No
	ith the	Director	10e. Street and Number	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code		10g.	Citizen of What C	country?
	sath w	Frail	4604 Bayonn		12 W	2120	6	N	U.S.	#-
ω.	ifter de Nr Item nimer	Funerai	11. Marital Status / 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 MNo			spanic Origin? (Spe n, Mexican, Pueno	Rican, etc.)	14. Race - Am Black, Wh	
9	be filed within 72 hours after death with the Maryland Hygiene. I Hygiene. I Hygiene. I hatural', or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show event, the Madical Examinar must be molified a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Y Year or Dates:	1	Yes 25 No	Specify:		Specify: B/	ack
15-	in 72 h	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give k	ent's Usual Occupa ind of work done of O NOT use retired	luring most of worki	ng 16t	o. Kind of Busines:	s/Industry
212	filed with Hygiene. ther than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Sel	+ EN	ployed		Janifo.	ria/
and	id be filed ental Hygid ked other ic event, L	Be	17. Father's Name (First, Middle, Last)	,			1)	(First, Middle, Mai	den Sumame)	
Maryla	2 should by and Menta Is marked sumatic ev	ဥ	Jamuel Scott 19a. Informant's Name/Relationship (7)	vpe Print) 1	9b Mailine	Address (Street a	Poro thy	I Route Number, C	ity or Town State	Zin Code)
	nd 2 ilth a 27 ts		Charles Ward	, , ,	4604	Bayon	1	D 11.	rore, le	d, 21206
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. Place	of Dispos	ition (Name of atory of other place		oate 200	. Location - City o	r Town, State
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	Wood	dlaw	n Conetes	my July	11, 2005 /	aftimor.	e Ud.
Ba	permit. Departrimporta any inju		a la C	Anders.	C	711 Ma	Dougla	& Funer	al Seri	7, ce 7.4.
	1		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Done cause on each line.	o not ente	r the mode of dying	g, such as cardiac o	or respiratory arrest,	. 24	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	. MYOCKES	nA	1 11	NFAL	2etio	N	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):	DENI	D 7	A-1111	Q-	24 HA18
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequent	ce of):	0141	10 4	Nicu	10	1 0,000
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	na of)-					
68760,	ate be executed hysician and the burial-transit	cal E		d	oo or).					
	nificating phy		IF FEMALE:	·						
Вох	death certifica e attending ph od for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 🗌	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
o.	0 0 9	nysic	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	1 5∐	Other (specify)				,
S, D	es that gned b	by PI	Part II. Other significant conditions co	ontributing to death but not resultin	g in the un	derlying cause give	en in Part I.	23e. Did tobac	• /	to the cause of death?
ord	w requires that been signed I should be det							1 Tes	2 □ No 3 F	Probably 4 Unknown
Record	e la has	Completed						24a. Was an autopsy performed	prior to death?	tutopsy findings available completion of cause of
Viita		Be Co	25. Was case referred to medical				26. Place of Death	1 X Yes 2 (Check only one)	No 12 Ye	s 2□No
o {	di is	2	10 192 57 140		Outpatient		4 Nursing Ho	me 5 Residence		ecify)
ono	ding f th. tuner	Certification:	27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Time of Injury	28c, Injury Work M 1□		28d. Describe how i	injury occurred	
Division	er dear	tifica	3 Suicide 6 Could not be determined		, farm, stre			28f. Location (Stree City or Town, S		Rural Route Number,
ā	urs aft eral Di									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1X Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my op	ie, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and du	e to the cause(s)
	To th To th comp	M	29b. Signatore and title of certifier	11/2	,	29c. License	number	29d.	Date signed (Mor	oth, Day, Year)
)	i\		/ / Warm	1 V. Em	o av	D L	2286		1112/0	5
	4	4	30. Name and address of person who of	completed cat se of death (Item 23	a) (Type, F	3PK	ROAD S	411023	BART	21212
::,	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A.	ه بو			1	
DH	MH 17 Rev 1/2		JUL 1 3 200	Believe St.	Sport 4					

ORIG!NAL

			1 - State Registrar	te of Maryland / Depa	artment of Hertificate of E	Death	R	eg. No. 201	75. 22015
	Physici /Medi		1. Decedent's Name (First, Middle, Last) LEVOY ANGELO W	lallace			2. Date of Deat Month 07		ear 929 P M
	Examir		4a. Facility Name (If not institution, give street a VETECANS Administration it		4b. City, Town, or 1 Baltim	ore		4c. County of	Death
	Funeral Director		5. Social Security Number 327-34-3578 6. Sex 1 2 2 (7. Age (In yrs. last birthday) 6 4 Yrs.	If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, 1 - 7 - 41		D. Birthplace (State or Foreign Country)
	the Maryland 28a-f show	ector	10a. State 10b. County MD 10e. Street and Number	10c. City, Town or Lo Baltimor	е			0. Cisi	10d. Inside City Limits 1 Yes 2 □ No
	3a or	iDir	1638 Abbotson St.		10f. Zip Code 21218			0g. Citizen of Wha USA	at Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene, item 27 is marked other then "neturel", or Itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 12. Wa Am 1 Never Married 2 Married 1 If Y	Mas 2 No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☐ No	panic Origin? (Spec , Mexican, Puerto Ri Specify:		14. Race -	American Indian, White, etc.
21215-0036	filed within 72 ho Hygiene. other then "neturent, Ire Medical	Completed	12th	leted) 16a. Dece (Give life. Engi	dent's Usual Occupat kind of work done du DO NOT use retired)	tion <i>uring</i> most of <i>working</i>		16b. Kind of Busin Private Buildin	
Maryland	should ba file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Thomas Wallace			18. Mother's Name (Maiden Surname)	
Mar	d 2 sho		19a. Informant's Name/Relationship (Type, Printsylvia Wallace (wi	,	ng Address (Street ar				
altimore,	8°= 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place of Dispo cemetery, crei	Trimble sition (Name of matory or other place)	Da	te :	20c. Location · Cit	ty or Town, State
Baltin	permit. Pag Department Important: I any injury o		' 4 □ Donation 5 □ Other (Specify) 21. Signafure of Funeral Section Licensee	2	n Forest 2.Name and Address 007 East	of Facility Wes	ley Ch	navis J	
	Priysician /Medical Examiner	niner	resulting in death) Sequentially list conditions.	that called the death. Do not enter on each line. To be used the death. Do not enter on each line. The death is a consequence of the consequence	er the mode of dying,	, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and nage 2 should be detached for use as the burist-transit	Physician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnanf in the past 12 months?		⊒Ectopic pregnancy] Other (specify)			23d. Date o Month	
<u>م</u>	quires that (n signed by uld be deta	þ	Part II. Other significant conditions contributing	g to death but not resulting in the u	nderlying cause giver	n in Part I.		_	ute to the cause of death?
Vital Records,	. a □	Completed					24a. Was ar autops perform 1 Yes 2	y prio ned2 dea	re autopsy findings available r to completion of cause of th?
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital		Other	26. Place of Death (
ion of	ding After fune	 		1 ☑ Inpatient 2 ☐ ER/Outpatier Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury a	4 Nutsing Home		nce 6 ∐Other (w injury occurred	Specify)
Division	Dir.	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury · At home, farm, str building, etc. (Specify)	eet, factory, office	28	f. Location (Sti City or Town		or Rural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	edicai	one) 2 Medical Examiner: On	To the best of my knowledge, death the basis of examination and/or ind d manner stated.	vestigation, in my opi	nion, death occurred	at the time, da	ate and place, and	I due to the cause(s)
	To To	Σ	29b. Signature and title of certifier	MD	29c. License		29	9d. Date signed (A	
11	AAU		30. Name and address of person who complete		Print)	Greene	C	D. 14	2005
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	NOTH	Ultene	>1	Dallind	K 41101
	Regist	ar	JUL 1 3 2005	Blow & A	are I				

5-04536		1 10430	State of Ma							-	niene	e.	
	•	For State Registrar	Otate of two	ii y tai k		tificate			(110 141		leg. No. 20) E 20016	
Obvisionia		1. Decedent's Name (First, Middle, Las	st)	-						2. Date of Dea Month	ith	3: Tirfie of Death	
Physicia /Medica	al .	JULIAN ARDALAN								July	5 20	005 2:05 P ^M	
Examine	er	4a. Facility Name (If not institution, give						Location o			4c. County of	Death Ore City	
Funeral	-	University Hospit 5. Social Security Number 6. S	ex 7. Age	(In yrs. la	ast birthday)	If Under	1 Year	re Ci	24 Hrs.	8. Date of Birtl		•	
Director		227-65-6984 X	X M 2□F]	.7	Yrs.	Months	Days	Hours	Min.	April	22, 1988	Birthplace (State or Foreign Country) Maryland	
and w.	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
Mary I-f sh	ţō	Maryland Harfor	rd		Fa	llsto	n					1 ☐ Yes 2 🔀 No	
h with the	ai Direc	10e. Street and Number 2303 Windswept Ct	; .			10f. Zip	Code	2104	7		10g. Citizen of Wha	at Country?	
Baltimore, Maryland 21215-0036 permit. Peges 1 end 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hydron. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be nutified at once.	Completed by Funeral Director	11. Marital Status The Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		'	Was Deced f Yes, spec 1 ☐ Yes 2			gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White	
72 ho	etec	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition u <i>ring</i> most	t of worki	ng	16b. Kind of Busin	ness/Industry	
within then the Man	dmo	Elementary/Secondary (0-12)	College (1-4or 5-N/A	+)		oo notus J den t	e retired))			School		
other	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sumame)		
ylar build by Menta Arked	2	Ali A. Zamani								eh Shak			
y Maryland end 2 should be file salth and Mental Hy n27 is marked oth er traumatic event.		19a. Informant's Name/Relationship (David O'Neil (Ste		2303	ailing Address (Street and Number or Rural Route O3 Windswept Ct. Fallst								
Battimore, semit. Peges 1 er Department of Hea mportant: if item ny injury or othe page.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Nat	lace of Dispo emetery, crer ional	p of Disposition (Name of later), crematory or other place) Onal Mem. Pk. 7-14-05 22. Name and Address of Facility Lassann Funeral Home					Falls Ch	y or Town, State	
Baff permit. Depart import sny inj ance.	-	21. Signature of Funeral Service Licer	ISOO .		22	Lassa 7401	Addres Ann H Bela	ot Facilit Uner Bir R	al H	ome altimor	e, Md. 2]	.236	
72 - 7 Are		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death e.	. Do not ent	er the mode	e of dying	g, such as	cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mulhph	ein	jurie	.5						Oriset and Death	
Examiner			Due to (or as a	a consequ	Tence of):								
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequ	ence of):								
3760, 6 ate be executed hysicien and he burial-transit	cai Exa	resulting in death) Last	Due to (or as a	consequ	uence of):								
687 lifficate g phys			d										
Records, P.O. Box 68760, C	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pre Other (spe					23d. Date o Month	f delivery Day Year	
rds, P.	۵	Part II. Other significant conditions of	ontributing to death bu	ıt not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	. /	ite to the cause of death? Probably 4 [Unknown]	
	Completed						_	24a. Was autop	sy prio med? dea	re autopsy findings available r to completion of cause of th?			
of Vital Physicien: Trinis certificet	Be	25. Was case referred to medical examiner?	Hospital:				04		of Death	(Check only o	ne)		
Of Phys	2	1 XYes 2 No 27. Manner of Death	28a. Date of Injur		ER/Outpatier			4 🗆 140			ence 6 Other	(Specify)	
Vision Attending r death. ector: After	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	A M	Bc. Injury Work 1 🔲 Y	:? ∕es 2.4 <u>7</u> H		driver.	i head "	n	
Division Tor Attending after death. Director: After	tifica	3 Suicide 6 Could not b 4 Homicide determined	8 28e Place of Inju	rv - At ho	me tarm str	1	, office				ites to	or Rural Route Number,	
Hospitel or 24 hours afte Funeral Dir itely filled in	4 Homicide building, etc. (Specify) Sheet 29a. Certifier 1 Certifying Physician: To the best of my knowledge, or								- 1	Ells+>v	RS and fre	Fell'ster (1)	
Division of Vita Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	one) 2 Medical Exam	niner: On the best of niner: On the basis of and manner sta	examinat	wledge, deat ion and/or in	vestigation,	in my op	oinion, dea	d place, a	ed at the time,	date and place, and	I due to the cause(s)	
To To Com	2	29b. Signature and title of certifier **Death of the certifier of the cer	1 - 0 0				OCMF	number			29d. Date signed (I		
3		30. Name and address of person who			23a) (Type,	Print) 1	11 E	Penn S	Stree		July 6 timore, M	2005 aryland 21201	
Sta	te		32. Registr		ture	Met.	. 0.						
Registra	ar	JUL 1											

DHMH 17 Rev 1/2001

Patient know as: 2011N, HEABERT Baltimore, Maryland 21215-0036

		For State Registrar 1. Decedent's Name (First, Middle, L	ast)	Ce	rtificate of	Death	2. Date of Death	eg. No.2 0 0 5	2 2 0 1 ·
Physici		HERBERT	S.	70	LIN		JULY	8 200	
/Medic		4a. Facility Name (If not institution, gi				r Location of Death	0027	4c. County of De	
LAGITIII		Sinai Hospital o	E Rallimore		Baltim	ore City			N/A
Funeral			Sex 7. Age (In yrs. la	st birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	1/18/1921». B	intholace (State or Fore
Director		219-07-2107 Usual Residence of Decedent	1X M 2□F 84	Yrs.	Month's Days	Flours IVAII1.	JAN. 19,	1921	GERMANY
Now Tel		10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Lim
a-f s	ctor	MD N/	4	BALT	IMORE				1 X Yes 2 □
ntal Hygiene. ed other than "natural", or liems 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What (Country?
238	alc	3211 CLARKS LAI	NE #307			21215			USA
ems	ne	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite etc
P =	F.	1 Never Married 2 Married	1 X Yes 2 □ No WWI If Yes, Give	T	1 ☐ Yes 2 ☒ No	Specify:	,	Specify:	WHITE
LEN,	d by	3 Widowed 4 Divorced	Year or Dates: ARMY		.,			open,y:	WIIIIE
"nat	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of worki d)	ing	16b. Kind of Busines	ss/Industry
han a	шb	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT USE PETIFEC DUNTANT	2)		ACCOUNTI	NG
other 1		17. Father's Name (First, Middle, Las	**1	ACCC	ONTANT	18. Mother's Name	/First Middle A		110
94 ol	Be		14	ZOLI	· NI	HERTHA		naiden Sumame)	DAVID
marked imatic ev	ို	JOSEPH	(Time Brief)					0	
item 27 is marked o		19a. Informant's Name/Relationship						City or Town, State	
iner		JOSEPH ZOLIN / 20a. Method of Disposition		_	ONIONA SUC			E, MD 212	
		1 Burial 2 Cremation 3	☐Removal from State cer	metery, cre	matory or other plac	ce)			
Important: I any injury o once.		`4 □Donation 5 □ Other (Spec			IAVAS CHES		1/2005		LSTOWN, MD
Important: If any injury or once.	Ш	21. Signature of Fureral Service Lic	ensee		Name and Addre	301		ON & BROS	
3 E # 01	Ш	/ Jan							, MD 21208
		23a. Part1. Enter the disease, or co shock, or heart failule. List on	mplications that caused the death. y one cause on each line.	Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	. Seosis						Onset and Death
edical miner		resulting in death)	Due to (or as a conseque	ence of):					0.
IIIIIEI	L	Sequentially list conditions,	b						
ii.	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
and -tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	anno offi					
sician and burial-transit	Θ		Due to (or as a conseque	erice or).					
ohysi the t	dicat		d						
attending physician for use as the buria	Physician/Med	IF FEMALE:	220 If upe outcome of						
or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of	death 3	□Ectopic pregnancy	/		23d. Date of o	lelivery Day Year
the the	/sic	1 Yes 2 No	4∏Pregnant at time of dea 9☐ Unknown	ath 5	Other (specify)				,
ed by the a	Ph	Part II. Other significant conditions	contributing to death but not result	ting in the	inderhins esses	en in Part I	23a Did tab	acco use contributo	to the cause of death?
15 eg	by	. 11.	_	வதிய மெடி	andonying cause giv	on mr diti.			Probably 4 Unknow
been si should	Completed	Congestive Hea	IT TOUTURE.				1 1 18		- John - John
O to	ple						24a. Was ar autops	v priort	autopsy findings availal o completion of cause o
as 2	no.						perform 1 ☐ Yes 2		
has e 2	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one	e)	
page 2		1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 □ E	R/Outpatie	nt 3 DOA	er: 4 Nursing Ho	me 5 Reside	nce 6 Other (S	pecify)
is certificate has director, page 2	0		28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur	y at	28d. Describe ho	w injury occurred	
is certificate has director, page 2	²	27. Manner of Death				Yes 2 □ No			
After this certificate has funeral director, page 2	²	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat			reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
After this certificate has funeral director, page 2	²	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At hon	ne, farm, st	,,,				
After this certificate has funeral director, page 2	²	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 390 Place of Injury At hon	ne, farm, st	,,,		,	, 3(2(0)	
After this certificate has funeral director, page 2	Certification; To	1 Accident 5 Pending investigat 3 Suicide 4 Homicide 6 Could not determine	be 28e. Place of Injury - At hon building, etc. (Specify) Physician: To the best of my know	rledge, dea	th occurred at the tir	me, date and place,	and due to the ca	tuse(s) and manner	as stated.
After this certificate has funeral director, page 2	edical Certification; To	1 Accident 5 Pending investigat 3 Suicide 4 Homicide 6 Could not determine	be 28e. Place of Injury - At hon building, etc. (Specify)	rledge, dea	th occurred at the tir	me, date and place, ppinion, death occurr	and due to the ca	tuse(s) and manner	as stated. ue to the cause(s)
After this certificate has funeral director, page 2	Certification; To	1 Matural 5 Pending investigat 6 Could not determine 29a. Certifier (Check only 2 Medical Ex	be d 28e. Place of Injury - At hon building, etc. (Specify) Physician: To the best of my know eminer: On the basis of examination	rledge, dea	th occurred at the tir	opinion, death occurr	and due to the ca	tuse(s) and manner	ue to the cause(s)
After this certificate has funeral director, page 2	edical Certification; To	1 Aural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 1 Check only one)	be d 28e. Place of Injury - At hon building, etc. (Specify) Physician: To the best of my know eminer: On the basis of examination	rledge, dea	th occurred at the time the ti	epinion, death occurr	and due to the ca	ause(s) and manner ate and place, and d	ue to the cause(s) nth, Day, Year)
After this certificate has funeral director, page 2	edical Certification; To	1 Aural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 1 Check only one)	be de 28e. Place of Injury - At hon building, etc. (Specify) Physician: To the best of my know eminer: On the basis of examination and manner stated.	rledge, dea on and/or ir	th occurred at the time the ti	epinion, death occurr	and due to the ca	ause(s) and manner ate and place, and d	ue to the cause(s)

			For	State of Marylan					-	ene	•
			1 - State Registrar				of Death			9. N2 0 0 5	22918
	Physici	an	Decedent's Name (First, Middle, Last)			_		1	2. Date of Death Month	Day Yea	3. Time of Death
-	/Media	al		ry Brann	n gar			-4 D - 10	June 24		10:45 P ^M
	Examir	er	4a. Facility Name (If not institution, give Larkin Chase Nurs			_	wn, or Location owie	of Death		4c. County of D	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday)	If Under 1 \		r 24 Hrs. 8	B. Date of Birth		Georges Birthplace (State or Foreign
	Director		190-07-3209]M 2DXF 91	Yrs.	MONUTS	ays Hours		ec. 4,	1913 PA	Birthplace (State or Foreign Country) A
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mary 1-1 shu	tor	MD Prince Ge	eorges Bo	owie						1X Yes 2□No
	ith the or 28s	Funeral Director	10e. Street and Number			10f. Zip Co	ode		10	g. Citizen of What	Country?
	s 23a	ral	14997 Health Cent				716			USA	
	ter de	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No	.S. 13.	Was Deceden If Yes, specify	t of Hispanic Or Cuban, Mexica	rigin? (Spec in, Puerto Ri	rfy Yes or No- ican, etc.)	14. Hace - A Black, W	merican Indian, hite, etc.
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itams 23a or 28a-1 show event. It e Modicul Excolor that he conflied at	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2⊠	No Specify	:		Specify:	White
<u>2</u>	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	dent's Usual C	done durina mos	st of working	1	6b. Kind of Busine	ss/Industry
12	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 4		no voruse i maker	retired)			Own Hon	
<u>5</u>	illed Hygi othar	Be Co	17. Father's Name (First, Middle, Last)		Home	maker	18. Moth	er's Name (First, Middle, M	aiden Sumame)	ile
Maryland	should be ind Mental I marked o	To B	Matthew Kelly				Ju1	ia Ru	ddy		
Jan	Pages 1 and 2 should b ment of Health and Ments ant: If item 27 Is markad ury or other traumatic ●		19a. Informant's Name/Relationship (Ty							City or Town, State	a, Zip Code)
	1 and Health iem 27		Michael Brannigan/ 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	ford Dr	ive Da		ille, MD	21032 or Town, State
JOL.	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Sac	emetery, crer red He	natory or othe art Ce	metery	6/30		Plains, H	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License				- ·				ıral Home
<u>m</u>	88 E 8		11218		1	6000 A	<u>nnapoli</u>	s Road	d Bowie	e, MD 20)715
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death ne cause on each line.	h. Do not ent	er the mode o	f dying, such as	s cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Caade	ac	AN.	14 the	uia			
	Examiner			Due to (or as a conseq	uence or):		1				
	D ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uance or,						1
	and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq.	uanao of\:						
8760,	The law requires that the death certificate be executed the sabeen signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Ical E			usilos di).						
9	ificate g phys as the	P		-							
Вох	eath certific attending p	an/M	Zob. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregr	ancv			23d. Date of o	
-	at the dea by the ati	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (special	fy)			Month	Day Year
0	that the ed by detac		Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying caus	se given in Part	l.	23e. Did toba	cco use contribute	to the cause of death?
rds	quires that n signed t uld be det	d by	Failure 1	o thrive					1 ☐ Yes	2 □ No 3 □	Probably 4 Munknown
Records,	e law requir has been si je 2 should	ompleted	Dementia	•					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
ž		Com							perform		?
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Other		Check only one		
ō	Phys or this oral di	To It	1 ☐ Yes 2 ☐ No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		Injury at			ce 6 Other (Si	pecify)
<u>o</u>	Attanding I r death. actor: After by the funer	atlo	1 Accident 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐]No			
Division	after death after death Diractor:	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, of	ffice	28	f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
Ω	To the Hospital or within 24 hours after To the Funaral Dirac completely filled in b	O	29a. Certifier Certifying Phys	ninioma Ta Ab a bast of succession							
	e Hos 24 hc e Fun etely (dical	(Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	restigation, in	ne time, date at my opinion, dea	nd place, an ath occurred	d due to the cau at the time, dat	ise(s) and manner e and place, and d	as stated. lue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				icense number		290	d. Date signed (Mo	onth, Day, Year)
						Do	0057	028		6-2	7-05
			30. Name and address of person who co	A	23a) (Type,						D. MD 21401
	Sta	te	31. Date filed (Month, Day, Year)	32. Resstrar's Signa	ture			1100	731/11		711.0 2170
	Regist		JUN 2 8 2	005 Kan		Smooth !	,				

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 2005

Registrar's Signature...

Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

2005

Elem & Specker

		1- State of Ma		artment of Health and <i>rtificate of Death</i>	l Mental Hygie Reg.				
Physici /Medi		1. Decedent's Name (First, Middle, Last) Dorothy Russell 1	Breeding		2. Date of Death	Da 20 05 9 Time of Degith			
Examir		4a. Facility Name (If not institution, give street and number) 7244 Harmony Road		4b. City, Town, or Location of De-	ath	4c. County of Death Caroline			
Funeral Director		213-22-9818 1 M 2X F	78 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthplace (State or Foreign Country) New York			
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Caroline	10c. City, Town or Le	Federalsbu	rg	10d. Inside City Limits 1 ☐ Yes 2 📆 No			
death with the Maryland ms 23a or 28a-f show Livest by notified at	I Director	10e. Street and Number 6158 Todd Road		10f. Zip Code 21632	100	Citizen of What Country?			
5-0036 72 hours after death with the Marylan natural', or Items 23s or 28s-f show dies Extenitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give If Yes, Give Year or Dates:	lo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
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C = 64 F		19a. Informant's Name/Relationship (Type, Print) Walter L. Breeding, Jr./Som		ng Address (Street and Number or 19 Andrews Lake		ty or Town, State, Zip Code) ederica, DE 19946			
altimore, I mit. Pages 1 and partment of Healt portant: If item 2 y injury or other?		20a. Method of Disposition 1 🏝 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disported Place of	matory or other place)		Location - City or Town, State deralsburg, MD			
Baltimo permit. Page Department of Important: If any injury or sonce.		21. Signature of Funeral Service Licensee Milhael 7. Calking	2	2. Name and Address of Facility ${ m F}$	ramptom F	uneral Home, P.A. Isburg, MD 21632			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (final disease or condition resulting in death) Due to (or as a line)	the death. Do not en le. A consequence of):	ter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death			
68 / 60, ficate be executed physician and is the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):						
ath certi	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
rds, P.O. I	by	Part II. Other significant conditions contributing to death but the second seco	not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?			
	Completed	Pulmonary Hype	rteus	ION	24a. Was an autopsy performed				
ng Phys ng Phys after this	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	6 □Other (Specify) njury occurred						
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	rry - At home, farm, str . (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)			
UI: To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.								
To t To t	Σ	29b. Signature and title of certifier	s MM	29c. License number	29d.	Date signed (Month, Day, Year)			
		30. Name and a ress of person who completed cause of de	30 Ma	Print) Wet St	Deuton	MQ.			
Sta Registi		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	1.70					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month WALTER CLAVEN /Medical SR. JUNE 26 2005 11:35 A Examiner 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year tf Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 921 9. Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Director 578-16-7255 84 January 3 Columbia.SC Usual Residence of Decedent the Maryland ahow 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f ahov The Medical Examinar must be notified at Director 1XYes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 20904 3421 Hampton Hollow Dr. Apt B U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No 1943-If Yes, Give Year or Dates: 1946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 7 Hygiene. $\substack{\text{Elementary/Secondary (0-12)}\\ 12th}$ College (1-4or 5+) Engineer Government othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William | Claven Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3421 Hollow Dr. # B Silver Spring, Maryland 20904 Walter Claven Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Maryland Veteran's 6/30/05 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Onset and Death Immediate Cause (Final Physician tente Myocarcha resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate the use IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Enbrussela accident 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 21-No 1 ☐ Yes or Attanding Physician: al director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation tniury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number MD D0055120 June 28 2005 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year,

JUN 2 9 2005

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32. Registrar's Signatury

P.O. Box 68760,

Division of Vital Records,

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			For Stata Registrar	State of	Maryland	•	artment tificate				•	giene Reg. N.2	005	22921
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	Funeral Director		5. Social Security Number 226–26–4737	6. Sex 7 1 □ M 2√2√F	'. Age (In yrs. ia 86	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Cor	place (State or Foreign intry)
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	r 288-	Funeral Director	VA WESTM 10e. Street and Number	1ORELAND	HAG	UE	10f. Zip	Code				10g. Citiz	en of What Cou	
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Baltimore,	Pages ment of snt: If I		1 ∑ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp		tate	COMF	•	,	1	7/1/	05	ALE	XANDRIA	, VA
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	Physici /Medic		James Harvey	Clark						June	Day	2009	0800M
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	t and Health em 27 ther tr		Elizabeth J.	Clark/ Wife	20b. Place of Disposition (Name of Date 20c. Location							Town State	
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Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any Injury or other tree <u>once</u> .		21. Signature of Funeral Servi		22. Name and Address of Facility Fleegle and Helfenbein Funeral PO Box 160 Greensboro, MD 2163								
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						tificate of				A 179	
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			· William Mi)			L	16675		JUNE	22	, 2005
1	Q		30. Name end address of person who completed cause of de	eath (Item 2	3a) (Type, P	rint)	MA		*.,		
	Stat Registra		31. Date filed (Month, Day Year) 2 3 2 05 32. Registr	ir's Signatur	8	MINSWICK					

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: (I tem 27 is marked other then "neturet", or items 23e or 28e-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

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l or Atte after dea Directo	Certification;	3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street City or Town, Sta	ural Route Number,							
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ro th	M	29b. Signature and title of certifier	00	29d. [Date signed (Mont	h, Day, Year)						
2011	D62520 June 26,											
		30. Name and address of person who completed cause of de.th (Item 23a) (Type, Print)										
		Maria K. D'Arbela, M.D. P.O. Box 70139, Rosedale, MD 21237										
Sta Registi		31. Date filed (Month, Day, Year) JUN 28	32. Pegistrar's Sign	H. Span	le de la company							
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				ORIGINAL								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Richard D. 8:11 a M deBronkart June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**⊠**M 2□ F 83 Yrs. 103-16-6665 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic avant, the Medical Examinar must be notified at 1 Yes 2 No MD Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 465 Leaf Court Itams 23a 21146 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is markad other than "natural, or Ital 1 ☐ Never Married 2 🖫 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: White Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Microfilm Records Salesperson 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eugene H. deBronkart Elinor Van Gelder Davies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m any injury or othar traum once. Anne M. deBronkart/Wife 465 Leaf Court, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 17, 2005 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Faneral Service Lice 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Consestive heart Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it airy, loading to immediate cause. Enter Underlying Cause (Disease or ripliry that initiated events resulting in death) Last Due to for as a nonsectioning of: Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: esn esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai within 24 hor To tha Funa completely fi (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 2 D41816 mn 30. Name and address of person who completed cause or geath (Item 23a) (Type, Print) Solomons Island Rd. Aunepoli's MD 2149 Charles W 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 0 2005

			1 - For State Registrar	State of M	aryland		artment rtificate			ınd M			05	22929
	Physic /Medi		1. Decedent's Name (First, Middle W. Kenneth	e, Last)	De	et w	eile	r			2. Date of De. Month June	ath _Day	Year -005	3. Time of Death
	Exami		4a. Facility Name (If not institution Renaissance Gardens)			Location of			4c. Coun	ty of Death	1
	Funeral Director		5. Social Security Number 195–12–5408 Usual Residence of Decedent	6. Sex 7. Ag		ast birthday) 32 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da Jan. 27	h y, Year) 1,1923	Con	place (State or Foreign intry) nsylvania
	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "naturel", or Itams 23a or 28a-f show cother traumetic event, the Medical Example must be notified at	Il Director	Maryland Monto 10e. Street and Number 3122 Gracefiel	omery	S	Town or Lo		Code	20904			10g. Citizen o Unit		10d. Inside City Limits 1 □ Yes 2 No ntry? ates
90036	hours after death turel', or Itams 2: al Exam mermus	ed by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	No .	1	∣□Yes 2	Ľ X No	Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	Spec		hite
121215-0036	filed within 72 Hygiene. Ither then "na ent, the Wedic	Completed	(Specify only highe Elementary/Secondary (212) 17. Father's Name (First, Middle,	t's Education st grade completed) College (1-4or	⁵5+	life. L	kind of worl OO NOT use	done di e retired) dent	Prod	uct	Researc		on Co	
Maryland	should be find Mental Findstreed of marked of umatic even	To Be		etweiler		19b. Mailin	a Address				(First, Middle, dshall			1 Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If them 27 is marked other then eny injury or other traumetic event, the Magnee.		Jeffrey R. Detw 20a. Method of Disposition 1 Burial 2 Remation 4 Donation 5 Other (S 21. Signature of 5 maps Service	3 □Removal from State		ropolit	sition (Name patory or off tan Cr Name and Onald	e of ner place remai Address V.	tory of Facility Borgwa	6/27 ardt	Funera	20c. Location Alexan 1 Home	-City or To dria, , PA	own, State Virginia
68760,	cate be executed // Medical bhysician and physician and street burial-transit	dical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any learning to hume-liste cause. Enter Underfusign Cause (Disease or injury that initiated events resulting in death) Last	a	a conseque Da a conseque U y	ence of):	or the mode	of dying,	such as co	Hh	r respiratory arr	sville est, IS	, Mar	vland 20705 Approximate Interval Between Onset and Death
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			30. Name and address of person v	HUMANA, 3	110 G	RACE	rint) FIEL	DR	DAD,	SIL				
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amin	er	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, o	or Location of	of Death		4c. County of I	Death
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eral ctor		5. Social Security Number 6. Sex 112 M Usual Residence of Decedent		69 Yrs.	Months Days	If Under Hours	Min.	. Date of Birth (Month, Day, Y 09/28/1	9. 935 Ma	Birthplace (State or Fore Country) Tyland
100		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Lin
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aumail cevent, the modified Expunder chart be notified at	by Funeral Director	1 Never Married 2 Married	Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub			fy Yes or No- can, etc.)		American Indian, White, etc. white
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	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month	Day Year 12:55 PM
	/Medic Examin Funeral Director			4c. County of Death, Cometh 9. Birthplace (State or Foreign)
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Imust be notified at	Director	WV Preston Horse Shoe Run 10e. Street and Number 10f. Zip Code 10g. C	1 ☐ Yes 3 ☐ No Citizen of What Country?
	th with		Rural Rt. 2 Box 215 26716 U	SA
36	after or Ite	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 3 Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, Sive Year or Dates:	14. Race - American Indian, Black, White, etc. Specify: White
2-0		ted		Kind of Business/Industry
121	be filed within 72 h. Ital Hygiene. Id other than "netu event, In Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Cool
d 2	filed v Hygie other 1	Be Co	10 Heavy Equipment Operator (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Coal en Sumame)
, Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I'm M	To B	Herbert Evans Ruth Elizabeth	Humphrey
Mar	d 2 sho h and 7 Is mu traum		Peggy Evans/ Wife Rt.2 Box 215 St. George, W	
	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c.	V ZOZO / Location - City or Town, State
altimore,	Pages nent of I ant: If its ary or o		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Texas Cemetery 07/02/2005 E	glon, WV
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es		21. Signature of Fundral Service Licensee St. Name and Address of Facility 1 Home, Inc. P.O. Box 186 Davis, WV	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	Interval Between Onset and Death Six months or man
Box 68760,	death certificate be executed s attending physician and d for use as the burial-transit	dical	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
P.O.	that the di ed by the detached	Phys	9 ☐ Unknown	o use contribute to the cause of death?
rds,	w requires that been signed E should be deta	ed by		2 ☑No 3 ☐ Probably 4 ☐ Unknown
Il Records, P.O.	e la has	Completed by Physician/Me	Respiratory distress probably due to pulmenty autopsy performed? Recent chamthern & hora faulus Emblism 1 yes 251	
Vital	sicien: Th certificate rrector, pag	Be c	25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Monatient 3 DOA Other: 4 Nursing Home 5 Residence	2 FO (0 1/2)
Division of	ttending Phys death. ctor: After this y the funeral dir	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No	
Divis	after de Directe	ertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, State Could not be determined building, etc. (Specify)	and Number or Rural Route Number, ate)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causer one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a and manner stated.	(s) and manner as stated, ind place, and due to the cause(s)
	To the within To the comp	ž		Date signed (Month, Day, Year) me 28, 2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles A. Welder MD 311 rV 44h street cartled MD 2 15	
	Sta Registr	2.3	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

			1 - For State Registrar		State of M	1arylan	-	artmer <i>rtificat</i>				lental Hy	giene Reg. No. '	2005	
	Dhysisi	20	Decedent's Name (First,	Middle, Last)								2. Date of De		Year	Time of Death
	Physici /Medic		Dolores		Irene			Fog	gle_			Iune		2005	9:38 P
	Examir	ner	4a. Facility Name (If not ins					4b. City,	Town, or	Location	of Death		4c. C	County of Dea	th
			Frederick M 5. Social Security Number	emoria.			last birthday)		deri	ck If Under	24 Hrs.	8. Date of Bi	Fr	ederic	
	Funeral Director		217-28-5806		M 2√2 F	70	Yrs.	Months		Hours	Min.	July 1	ay, Year)	Co	thplace (State or Foreigi ountry) cyland
	D		Usual Residence of Deced									sury r	, 1337		yianu
	arylar show	-		County rederic	1.		y, Town or Lo cederic								10d. Inside City Limits
	Ba-1	Directo	Maryland F1	rederic	K.	FI	edelle								1X Yes 2 □ No
	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or liems 23a or 28a-1 show event, it to Madical Exertainer must be putilised at	al Dir	200 East 16	Stree	t			10f. Zip	2170 1	l				en of What Co USA	ountry?
	ems ;	Funeral	11. Marital Status	1	2. Was Deceder Armed Forces	nt Ever in U.	S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Sp.	ecify Yes or No Rican, etc.)	D- 1-	4. Race - Ame Black, Whit	
ရှ	or it	by Fu	1 Never Married 2		1 ☐ Yes 2 ☐ If Yes, Give	No		1 □ Yes		Specify:		,		Specify:	White
9500-91212	tural'	ed D	3 Widowed 4 □ Di	cedent's Educ	Year or Dates	i:	16a. Dece	dont's Heu	al Coouna	tion.					
<u>.</u>	filed within 72 Hygiene. Ither then "nater"	Completed	(Specify only	highest grade	completed)	- \	(Give	kind of wo DO NOT u	rk done d	turing mos	t of work	ing	IOD, KIN	d of Business	Andustry
717	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4o	r5+)	Т	eller						Banking	
	be filed ital Hygird of other event,	Be C	17. Father's Name (First, M	fiddle, Last)						18. Mothe	er's Name	e (First, Middle			5
Maryland		To	Carrol1		S.		Rowe				othy			Uterma	
<u>a</u>	2 s a le		19a. Informant's Name/Re		oe, Print)							al Route Numb			
_	1 and Health em 27 ther tr		Steve Fogle, 20a. Method of Disposition			20b. P	lace of Dispo			Dr.		kersvi		ation - City or	
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 🛎 Crem	ation 3 R	emoval from Stat	e C	emetery, crei	matory or o	other place						
	artme orten injury		'4 □ Donation 5 □ O		<u> </u>	Fre	deric	k Cre	mato nd Addres	ry 6	/28/	2005 uffer 1	Fred	erick,	MD
n	permit. Pages 1 Department of H Importent: If ite any injury or otl once.		1 Local	MX	/1.	_						ike, Fi			
	**		stock obeart failure	ase, o complice. List only on	cations that caus e cause on each	ed the death line.								zekyno	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	•	0100		ar	ery	di	SEG	SE			Crisot and Boath
	Examiner		, cooling in county		Due to (or a	is a consequ	uence of):		1						
	- 0	e.	Sequentially list conditions if any, leading to immediat	ө	Due to (or a	is a consequ	uence of):								
	d d ansit	Examiner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	1											
o Î	exec an an rial-tr		resulting in death) Last		Due to (or a	is a conseq	uence of):							-	
8/60	cate be executed physician and the burial-transit	dlcal		€ d											
9	ing ph	Med	IF FEMALE:												
ROX	The law requires thet the death certificate be executed the has been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregna in the past 12 months	aiii	3c. If yes, outcom 1 ☐ Live birth	2 ☐ Fetal	death 3]Ectopic p					23	3d. Date of del	livery Day Year
0	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	.	4□Pregnant 9□Unknown		eath 5□	Other (s	oecify)					WORTH	Day 16ai
2	res thet the de igned by the a be detached t	Ph	Part II. Other significant c	onditions con	tributing to death	but not resi	ulting in the u	nderiving o	ause give	n in Part I		23e. Did	tobacco us	e contribute to	the cause of death?
Records ,	uires sign Id be	d by	emoh	y sem			-						Yes 2□		obably 4 Unknown
Ö	w require been si should b	lete	tood	Car	cer							24a. Was	an	24h Wara ai	Itopsy findings available
	The lavate has	Completed	0,000	-								auto perfe	ormed?	death?	utopsy findings available completion of cause of
Vital		a	25. Was case referred to n	nedical						26. Place	of Death	1 ☐ Yes	2 No	1 🗆 Y <i>e</i> s	2□ No
	d is	To B	examiner? 1 ☐ Yes 2 🛣 No	Н	ospital: 1 □ Inpa	tient 2	ER/Outpatier	nt 3 🛣 DO	Othe	ar-		me 5 □ Res		□Other (Spe	cify)
n of	ding Ph h. After thi funeral		27. Manner of Death	Pending	28a. Date of In (Month, E	jury Jay Year)	28b. Time o	f :	28c. Injury Work	at		28d. Describe	how injury	occurred	
<u>S</u>	tendii leath. tor: A the fu	catl	2 Accident	investigation Could not be				М		res 2□	No				
DIVISION	or Att	Certification:		determined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i>)	ome, farm, sti /)	eet, factor	y, office			28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,
	pitel ours a erel [29a, Certifier 1 💢 C	ertifying Phys	ician. To the her	at of multon	uladaa daat	h	-		d -1				
	24 hos 24 hos Fun etely	Medical	(Check only 2 M	edical Exemin	icien: To the bes er: On the basis and manner:	of examina	tion and/or in	n occumed vestigation	, in my op	e, date an pinion, dea	id place, th occurr	ed at the time,	date and p	ind manner as place, and due	s stated. to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of	certifier	\			29	c. License	number			29d. Date	signed (Monti	h, Day, Year)
	0		100	ms (x	Magas	. N	0 (D3	6421			/	1/27/	2005
			30. Name and address of p	-	mpleted cause of	death (Item	1 23a) (Type,	Print)						1-11	
			James Am	erena	90	93 Ric	lgefie	ld Dr	#10	04.	Fred	erick,	MD 2	1702	
	Sta		31. Date filed (Month, Day	Year) Q 21	32. R	strar's Signa	ture	Sant		-					
	Regist	al		~ 4	200 E		D. A	U.含意本的	7						

DHMH 17 Rev 1/2001

			For State Registrar		State o	of Mary	yland / De	epartme Certifica	nt of F te of	leaith <i>Death</i>	and N	fental Hyg	giene20	05	22	934
	DI		1. Decedent's Name	(First, Middle,	Last)							2. Date of Dea			3. Time	of Death
	Physici /Medio		Kathryn	Ann Fr	ishkorn							June 26	5, ^{Day} 2005	Year	2:13	1 р м
	Examir		4a. Facility Name (If I	not institution,	give street and nu	m <i>ber)</i>		4b. Cit	, Town, o	r Location	of Death		4c. County	ol Death		
			8080 Kee						lkrid				How	ard		
	Funeral		5. Social Security Nu		. Sex 1 □ M 2 1 F	7. Age (li	n yrs. last birtho	Month	or 1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	9. Birth	place (Stat ntry)	te or Foreign
	Director		215-62-52 Usual Residence of D				51 Yr					Oct. 19	, 1953	Ma	rylan	nd
	show			10b. County		10	oc. City, Town o	r Location							10d. Inside	City Limits
	Many Stah	to	Maryland	How	ard		Elkr	idge							1 □ Y	es 2 🔀 No
	r 28a	Director	10e. Street and Num	ber				10f. Z	ip Code				10g. Citizen of W	hat Cou	ntry?	
	23e o	O E	8080 Ke	eton Ro	oad				21075				1	USA	•	
	deat	Funeral	11. Marital Status		12. Was Deci		r in U.S.	13. Was Dec	edent of H	lispanic Or	igin? (Sp	ecity Yes or No- Rican, etc.)			can Indian,	,
98	or It		1 Never Marrie			2 X No		1 🗆 Yes		Specify.		rican, etc.)		c, White, Whi		
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or Items 23e or 28e-f show the Midleal Examiner mast be notified at	d by	3 X Widowed 4		Year or D	ates:										
15	n 72 "nat	Completed		15. Decedent's y only highest	grade completed)		16a. D	ecedent's Us live kind of v le. DO NOT	ual Occup ork done i	ation during mos	st of work	ing	16b. Kind of Bu	siness/In	dustry	
12	filed withi Hygiene. other then	E C	Elementary/Second 12	dary (0-12)	College (1-4or 5+)		ecept		•			7	. ~		
	filed Hygi other	a	17. Father's Name (F	irst, Middle, La	st)			ecebr.	LOHES		er's Name	e (First, Middle,	Anima Maiden Sumami		re	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Menal and the M	To B	Isaac Ca	udill								Lorick		,		
ary	shou ind M mar umat	-	19a. Informant's Nan	ne/Relationship	(Type, Print)		19b. N	ailing Addre	ss (Street		-	al Route Number	r, City or Town, S	State, Zip	Code)	
	1 and 2 Health a lem 27 Is		Carrie L	. Cippe	rly/ Dau	ighte						ederick				
ore,	of He man	1	20a. Method of Dispo	sition	☐Removal from	01-1-	20b. Place of D cemetery,	sposition (N	ame of other plac	ce)		Date	20c. Location - (
Ĕ	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ortents if item 27 is marked other then "naturel", or items 23e or 28a-f show in it is item 27 is marked other then "naturel", or items 23e or 28a-f show in items in the market of the market is a shown; the Madeal Examinar mast be notified at a.		`4 □Donation 5			State	Metropol:	tan Ćre	mator	y	υu		Alexandı	cia,	Virg	inia
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any Injury oc ether tr once.		21. Signature of Fan	eral Service Lie	amse	4		Franci 500 Ur	ing Addre	ss c бiч	ins Blvd	Funeral , W, Si	Home Ir lver Spr	nc ing,	, MD	20901
	15 170		23a. Part1. Enter the shock, or heart	disease, or co	mplications that	w sed the	death. Do not	enter the mo	de of dyin	ng, such as	cardiac	or respiratory arr	est,		Approxim Interval B	nate
	Physician		Immediate Cause (F disease or condition	inal		Can									Onset an	id Death
	/Medical		resulting in death)		a		onsequence of)							_	21 da	ays
	Examiner		Sequentially list cond	ditions.	b											
	be sit	Examiner	Sequentially list conditions, leading to immorause. Enter Underland	nediate ying	Due to	(or as a co	onsequence of)									
	xecut and Il-tran	хап	that initiated events resulting in death) La		c. Due to	(or as a co	onsequence of)	_						-		
8760,	cate be executed physician and the burial-transit	ai				,	,									
687		edicai			0.											
Вох	death certific e attending p id for use as	n/M	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, out	tcome of p	pregnancy						23d. Date	ol delive	arv	
		Physician/Me	in the past 12 m 1 □ Yes 2 □		4□Pregn	nant at tim	Fetal death e of death	3 ☐Ectopic 5 ☐ Other (s					Mon	th	Day	Year
P.0	at the de by the a	hys	9 Unknown		9□ Unkn											
Records, I	The law requires that the sate has been signed by the bage 2 should be detache	by	Part II. Other signific	ant condition	s contributing to de	eath but n	ot resulting in th	e underlying	cause giv	en in Part I	l.		pacco use contri es 2 □ No			
ပ္က	e law requ has been le 2 shoul	Completed										24a. Was a	n 24b. W	ere auto	psy finding	s available cause of
Ä	The ate has page	E O										autops perforr 1 Yes 2	ned? de	eath?		cause or
Vital	Phyeiclen: Th this certificate al director, pag	Be	25. Was case referre	d to medical						26. Place	of Death	(Check only on				
of V	Phyeic this coral dire	0	1 ☐ Yes 2 🐴 N	o	Hospital: 1 □ I	Inpatient	2 ER/Outpa		- 100	4 LINU	ursing Ho	me 5% Reside	ence 6 Othe	(Specify	V)	
		on:	27. Manner of Death 1★ Natural	5 Pending		of Injury th, Day Ye	28b. Tim Inju	ry	28c. Injun Worl			28d. Describe ho	w injury occurre	d		
Sign	ten leati tor: the	icat	2 Accident 3 Suicide	investigat	be	-61-1	At home form	М	-	Yes 2 🗆	-	001 1 1 10				
Division	l or Attenation after death Director:	Certification;	4 Homicide	determine	od 286. Place buildi	ing, etc. (S	- At home, farm Specify)	. street, facto	ry, office			28I. Location (St City or Town	reet and Numbe n, State)	r or Rura	I Route Nu	ımber,
_	spite		29a. Certifier 1		Physicien: To the	best of m	v knowledge, d	eath occurre	at the tin	ne. date an	nd place.	and due to the ca	use(s) and man	ner as st	nated	
	To the Hospitel or At within 24 hours after of To the Funerel Direc completely filled in by	Medical	(Check only 2 one)	Medicel Ex	eminer: On the b	asis of exa	amination and/o	r investigatio	n, in my o	pinion, dea	th occurr	ed at the time, da	ate and place, ar	nd due to	the cause)(s)
	To the within To the comp	Ň	29b. Signature and ti	tle of certifier	XIN			2:	c. License	e number		2	9d. Date signed	(Month,	Day, Year)	
•	25		•		YW				200	33	29	3.	June	27,	2005	5
			30. Name and address Frederic	s ol person wr k P. Sm	ith, M.D	. 54	454 Wis	consin		nue,	#1300	O, Chevy	Chase,	Md 2	0815	
	Sta Registr		31. Date filed (Month		2005	tegistrar's	Signature	facili	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month William Fradewick 2005 Ju /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X**M 2 □ F Yrs. **Director** 217 22 5492 Jan 26, 1928 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5783 Flagflower Place 21045 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lutheran Minister Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be William F. Gunther, Sr. Martha Petzold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health ar 5783 Flagflower Place Columbia, MD 21045 Grace B. Gunther/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ites
any injury or ott 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 6-28-2005 | Catonsville, MD Metro Crematory ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 22x +12LA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions il any, leading to infriediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 🗷 🗝 1 ☐ Yes 2 HNo Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 LNo Certification: To 1 Propatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manor of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Roser 30. Name and address objects on who completed cause of death (Item 23a) (Type, Print) 122 Sla

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		1 - For State Registrar	State of I	Maryland		artmen tificat				-	_	200	5	229	36
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Director		Usual Residence of Decedent	1□M 2X□F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da April	^y 3 ^{Year)}	917	Po	land	
he Marylar 8a-1 show	ector	Maryland Montg	omery		Town or Lo	Spr								d. Inside City	
23a or 2	Funeral Director	10e. Street and Number 14917 Notley R	oad			10f. Zip		910		Ur		d Stat			ric
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, I'm Medical Examinat must be indiffed at ance.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	s? X No		Vas Deced fYes, sped I ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)		14. Race - A Black, V Specify:	White, et		
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ould be filed Mental Hyg arkad othe atic event,	To Be C	17. Father's Name (First, Middle, Las ISAAC GRABINA								(First, Middle, SHKOVIT		Sumame)			
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cate be executed physician and the buriat-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dire to (or	as a conseque	mice of jr	1 2/									
I ne law requires that the death certificate are has been signed by the attending phys page 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal d at time of dea	leath 3 🗆	Ectopic pr				-		23d. Date of Month	,		ear
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he Hospl n 24 hou ne Funer sletely fill	edical	29a. Certifier (Check only one) 1 X Certifying Pl 2 Medical Example 1	nysician: To the be miner: On the basis and manner	of examinatio	ledge, death on and/or inv	occurred estigation,	at the time in my opi	, date and nion, deat	d place, a h occurre	nd due to the o d at the time, o	ause(s) date and	and manne place, and	r as state due to th	ed. ne cause(s)	
To the within To the comp	Me	29b. Signature and title of certifier July 1 30. Name and address of person who	Markey	M.D.	23a) (Tuna 1		License					e signed <i>(M</i> 22/200		y, Year)	
2		EDWARD L. MOSLEY,	MD 1011	1 WOOD	LAURI	EL WA)WIE,	MAR	YLAND	207	21			
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			For State	State of Maryla		artment of F rtificate of		Mental Hy	giene	
İ	Physici		1 - State Registrar 1. Decedent's Name (First, Middle, Last) Steven Francis	Gaughan	Cei	runcate or	Dealii	2. Date of Dea) 5 2. 2m-9 Gath 2005 5:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give s		er		r Location of Death	<u> </u>	4c. County	of Death ce George's
	Funeral Director		Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt June 16	th , 1964	9. Birthplace (State or Foreign Country) Massachusetts
	yland		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	with the Ma s or 28a-f s be notified	Director	Maryland Prince Ge 10e. Street and Number 216 Lastner Lane	orge's C	Greenbel	10f. Zip Code	20770		10g. Citizen of W Unite	/hat Country?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event. The Medical Exacilisar must be rodified at	by Funeral		12. Was Decedent Ever in Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race Black Specify.	e - American Indian, k, White, etc. : White
21215-0036	id within 72 ho giene. er than "natur i tre Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired ICE Offic	during most of work d)	sing		siness/Industry George's County Department
nd		a l	17. Father's Name (First, Middle, Last)	Gaugha			18. Mother's Nam		Maiden Sumam	Daley
Maryland	permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event, ITAM ODGS.	δ.	Edward 19a. Informant's Name/Relationship (Type Donna F. Gaughan -	pe, Print)		ng Address <i>(Street</i> Lastner L	and Number or Rui ane Green		er, City or Town, aryland	
nore, l	ages 1 and of Heall to rother		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R		cemetery, cre-	osition (Name of matory or other place Memorial	ce)	Date 6/25/20		City or Town, State
Baltimore,	permit. P Departme Importan any injur:		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	99			ss of Facility Borgwardt			PA Maryland 20705
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٥.	uires that the de signed by the a Id be detached f	þ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	underlying cause giv	ven in Part I.	23e. Did ti	•	ibute to the cause of death? 3 Probably 4 Unknown
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Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Ott	26. Place of Dear			
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Divisi	Dir.	Certification:	3 ☐ Suicide 6 ☐ Could not be 45 Homicide determined	28e. Place of Injury · A building, etc. (Spe	t home, farm, st		e	28f. Location (S City or Tox	Street and Numbe	er or Rural Route Number, 35 South Laurel D 20708
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Physical Check only one) 2 X Medical Examination	sician: To the best of my inter: On the basis of exame and manner stated.	knowledge, deat ination and/or in	th occurred at the tinvestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and mandate and place, a	nner as stated. and due to the cause(s)
•	Mithi Comp	Ň	29b. Signature and title of cartifier	for M		29c. Licens			June 22,	(Month, Day, Year) 2005
_	۲۳		30. Name and address of person who co	GAN			n Street	Baltin	nore, Man	ryland 21201
	Sta Regist		31. Date filed (Month, Day, Year) JUN 28 200	39. Registrar's Signature J	snature spe	de				

Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Ma		d / Depa		of H	ealth a		ental Hy	giene	9 .	, , ,	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) EARL HAMILTON	JR							2. Date of De JUNE	Reg. No eath Da	20) 5) 85	2т <u>те</u> 3 00 дн 8
	Examin		4a. Facility Name (If not institution, give s FREDERICK MEM		SPI	PAL	4b. City, T FREI		Location o	f Death		l l	County REDE		K
	Funeral Director		213-22-1222	M 2□F 7. Age		ast birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di July 1	rth ay , Year) 6 , 1	926	9. Birthp Cow Mary	olace (State or Foreign otry) Land
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. I have 23e or 28e-1 show other than "natural", or Itams 23e or 28e-1 show other traumatic event, the Medical Exacting International Confidence of the confidence of	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	:k	10c. City	, Town or Lo	cation Marke	t						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Funeral Director	10e. Street and Number				10f. Zip (,				tizen of W		•
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036	ours after or transfer or tran	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ∰Yes 2 □ N If Yes, Give Year or Dates:	。 WWII		fYes,speci 1□Yes 2			, Puèrto I	cify Yes or Na Rican, etc.)		Black Specify	k, White,	etc. Thite
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ary	should ind Men marka umatic	Ը	Earle Hamilton 19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailir	ng Address	(Street a			Smith Route Numb	er, City	or Town,	State, Zip	Code)
	1 and 2 : Health ar em 27 is wher trau		Edith Hamilton /	Wife			Rawl			Ne	w Mark	et,	Mary:	Land	21774
Baltimore,	Pages 1 ar nent of Hea int: If item : iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ace of Dispo ometery, cren dericl			y .	June 2	24, 005			-	own, State Maryland
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	Sta		31. Date filed (Month, Day Year)	32. Registr	s Signat	ture			y	, 110	- y - and	C1/			
	Regist	ar	JUN 2	2002	Ballett.	1 15	A com	A ST							

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	Examir	ier	804 GRANDIN AVE			4b. City, Town, or ROCKVI		eath		ounty of Death	RY
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	42 g g		19a. Informant's Name/Relationship (Ty MICHAEL HANCOCK		1			r Rural Route Numb EW DRIVE	•		
Baltimore,	0 = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ▼ 1 □ Donation 5 □ Other (Specify)	Removal from State	lace of Dispo emetery, crer	sition (Name of natory or other plac HURCH	ce)	Date	20c. Loca	tion - City or To	own, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Finer II Service Licens	99	H P	Name and Address ILTON FI	ss of Facility UNERAI 86, E	L HOME BARNESVI			0838
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68760,	ate hy:			d							
.O. Box	The law requires that the death certific tie has been signed by the attending p oage 2 should be detached for use as:	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	R3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
ecords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.		tobacco use Yes 2 1		ne cause of death?
\mathbf{x}		Completed						24a. Was auto perfo 1 Yes		prior to cor death?	psy findings available mpletion of cause of
Vital	Physician: Th this certiticate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	ER/Outpatien	it 3□ DOA Othe	00	Death (Check only)		Other (Specific	141
ion of			27. Manna of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	y at	28d. Describe			y)
Division	or A after Dire in b	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (City or To	Street and N wn, State)	Number or Rura	al Route Number,
	e Hospital 24 hours a e Funeral letely tilled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the tim vestigation, in my of	ne, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) an date and pla	nd manner as st ace, and due to	tated. the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifier	- SSA	_	29c. License	a number 4 3 08	3		signed (Month,	*
	X		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,			#300 120			
	Sta Registr	ite '	31. Date filed (Month, Play, Year) 20	05 32 segistrar's Signat		and !			(- بر بن سب

			1- State of Man		artment of Ho			ene	
	Physici		1. Decedent's Name (First, Middle, Last) CHARLES M. JOHNSON, SR.				2. Date of Death Month June	23 2005	2 Time questo
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 1010 Avery Place		4b. City, Town, or Up	Location of Death per Mar1be		4c. County of Deat	George's
	Funeral Director		240-74-9582 ¹፟፟፟™ ²□F	In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Apr. 6,	ear)	hplace (State or Foreign untry) nnsylvania
	ne Maryland 8a-f show oliffed at	Director	Maryland Prince George's	Oc. City, Town or Lo	per Marl	boro			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with ti		10e. Street and Number 1010 Avery Place		10f. Zip Code	20774	10g	g. Citizen of What Co United	
036	be filed within 72 hours after death with the Maryland ttal Hyglene. do other then "netural", or items 23e or 28e-f show event, the Medical Excendent must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Married		_ 37	spanic Origin? (Spec n, Mexican, Puerto R Specify:	rify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify: B	
Maryland 21215-0036	e filed within 72 ho Il Hygiene. other then "netu vent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th	(Give	DO NOT use retired)	turing most of working	g 16	6b. Kind of Business	
and 2	ould be filed Mental Hygid arked other atic event, II	Be	17. Father's Name (First, Middle, Last) Preston Willie John	nson		18. Mother's Name			
Mary	and and Is m	10	19a. Informant's Name/Relationship (Type, Print)				Route Number, (City or Town, State, 2	
			1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	9)	ite 20	c. Location - City or	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License		. Name and Address		ewart Fu	Brentwo neral Hom Wash., DC	e
	Physician		23a. Part1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	e death. Do not ente					Approximate Interval Between Onset and Death
,8760,	/Medical Examiner bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conditional co	consequence of):					
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	v	the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy performe	24b. Were au prior to death?	utopsy findings available completion of cause of
o	ding Physician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 27. Manner of Death 1 XNatural 5 Pending (Month, Day Y) 2 Accident investigation		28c. Injury Work	at 2		ce 6 Other (Spe	cify)
Division	al or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	- At home, farm, str (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of representation of the basis of evaluation and manner states	kamination and/or inv	n occurred at the time vestigation, in my op	e, date and place, ar pinion, death occurre	nd due to the cau d at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	Garage	29c. License	D28079	290	June 28,	
(D(5))	30. Name and address of person who completed cause of deal Francine Higgs-Shipman				., #100-		le, MD 20705
	Sta Regist			s Signature	W)		.,		

		1 - For State Registrar	State of	f Marylan		artment of rtificate o			, ,	ene	
Dhyei	oion	1. Decedent's Name (First, Middle	e, Last)					N.A	ate of Death	Day Van	32 inge of Gelia
Physic /Med	lical	Goldie G.							ne 22,	2005	12:34 P.M
Exam	iner	4a. Facility Name (If not institution				4b. City, Town		of Death		4c. County of Death	
Funera		Hebrew Home o 5. Social Security Number		7. Age (In yrs. I		If Under 1 Yea		r 24 Hrs. 8. Da	ate of Birth Month, Day,	Montgome 9. Birth	nplace (State or Foreign
Directo		150-09-0938	1□M 2□F X	9	3 Yrs.	Months Day	s Hours	Min. (A Ma	ay 6	1912 New	Jersey
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
Maryla f sho	jo	Maryland Montg		1	kville						1 X Yes 2 □ No
ING Z I Z I 3-UU.30 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or items 23a or 28a-f show event. The Medical Exatt har must be nytilled at	Director	10e. Street and Number				10f. Zip Code	•		109	g. Citizen of What Cou	untry?
th with		4607 Brad Cour	t			20853				U. S. A.	
r dea	Funeral	11. Marital Status	12. Was Dece Armed For nied 1 □ Yes	dent Ever in U.	S. 13.	Was Decedent o	f Hispanic Or uban, Mexica	rigin? (Specify Y	res or No-	14. Race - Amer Black, White	
within 72 hours after ene. "natural", or Ite the Wedical Examina	by Fu	1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced		e	1	1 □ Yes 2 🛣 N				0	ite
5-0056 72 hours aft natural', or		15. Deceden	t's Education	1105.	16a. Dece	dent's Usual Doo	upation		16	6b. Kind of Business/I	
L I U	plet	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	(Give	kind of work dor DO NOT use reti	ne during mos red)	st of working			,
C Z I.	Completed	12 Years			Facto	ory Work				Clothing	
and de filk	e	17. Father's Name (First, Middle, Jake Steelma						er's Name <i>(Fir</i> s nnie Kus		aiden Sumame)	
Tarylan 2 should be and Mental 1s marked eumatic ev	2	19a. Informant's Name/Relations			10h Mailie	na Addrona (Stra				City or Town, State, Z	In Code)
Ma nd 2 si ith an 27 is r		Dorothy I. Har		hter		Brad Co				•	853
Ore, Maryial les 1 and 2 should b of Health and Ments if item 27 is marked or other treumatic e	5	20a. Method of Disposition		20b. P		sition (Name of matory or other p		Date		Oc. Location - City or 1	fown, State
Page Page July 2	1	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ⊡ Removal from S Specify)	SIAIU		illah Ce		5/24/200	05 P	leasantvil	le, N. J.
baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe	i ka	21. Signature of Funeral Service	Licensee		22	Name and Ado	tress of Facili	itv			
405 6 6	8	Conald C	. Xlstt	temye	2 — 109	1 Rocky	ille I	ike, Ro	ckvil	on, Inc. le, Maryla	nd 20852 Approximate
Pnysiciar /Medica Examine		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	a. Due to (or as a consequence or a consequence or a consequen	uence of):	heart		ase			Interval Between Onset and Death
death certificate be executed e attending physician and dor use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ	uence of):						
death certifi death certifi e attending of for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1☐Live b	come of pregna irth 2 Fetal ant at time of de own	death 3	Ectopic pregnar Other (specify)				23d. Date of deliver Month	very Day Year
v 8 8 8	by P	Part II. Other significant conditi	ons contributing to de	eath but not resu	ulting in the u	nderlying cause	given in Part	I. 2		cco use contribute to	
Hec e taw has b	completed								24a. Was an autopsy performe	ed? / death?	copsy findings available ompletion of cause of
ysicien: Thysicien: The is certificate director, pag	Be C	25. Was case referred to medica examiner?	1				26. Place	e of Death (Che			
_ \$.≅ .₫	2	1 ☐ Yes 2 ☑ No			ER/Outpatier	IT 3 DOA				ce 6 □Other (Spec	ify)
UNISION O I or Attending Ph after death. Director: After th	ertification:	27. Manny of Death 1	gation	of Injury h, Day Year)	28b. Time of Injury	W	jury at fork? ☐ Yes 2 ☐]No		injury occurred	
UIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	O	4 Homicide determ	nined 256. Flace buildir	ng, etc. (Specify	′)	reet, factory, offic		С	City or Town,		
To the Hospitel within 24 hours a To the Funerel completely filled	ledical	(Check only 2 Medical one)	examiner: On the ba	asis of examinat	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date ar y opinion, dea	nd place, and du ath occurred at t	ue to the cau the time, date	se(s) and manner as e and place, and due	stated. lo the cause(s)
Vith Corr	Z	29b. Signature and title of certifie	A 1/11	0			nse number	0		d. Date signed (Month	
4		tary	3 W/W	5			252			m 22,20	:0T
1		30. Name and address of person	1. ms	6121	Munt	Test R.	oad	Rock.	ville 1	Maryland	20152
	tate	31. Date filed (Month, Day, Year,	32 R	egistrar's Signa	ture	AP n				Tiano	7-0-0
Regis	trar	JUN 28	2005	ever B	Giple	MEL					

			1 - For State Registrar	State of Maryland	/ Depart		alth and Me	-	ie	
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Ethel W. Lerne 4a. Facility Name (If not institution, give s)	treet and number)	48	o. City, Town, or Lo		June 2	22. 2005 Ic. County of Death	27:30 PM
	Funeral Director		3507 Jeffry Str 5. Social Security Number 104-01-5801 Usual Residence of Decadent				Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Yea Nov. 27,	Montgome 9. Birthy Cour 1918 Nev	ery place (State or Foreign ntry) W York
	id be filed within 72 hours after deeth with the Maryland fental Hygiene. Ked other than "natural", or Items 23a or 28a-f show the ovent, the Medical Examinal must be notified at	ector	10a. State 10b. County Maryland Montgome							10d. Inside City Limits 1 Yes 2 No
	23a or	ai Dir	3507 Jeffry Street	:		10f. Zip Code 20906		10g. C	U. S. A	•
030	be filed within 72 hours after deeth with the Marylan Ital Hygiene. Id other than "natural", or litems 23a or 28a-f show event, It e Medical Experimental be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Decedent of Hispons, specify Cuban, I	anic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:	
21213-0030	e filed within 72 ho it Hygiene. other then "natur vent, It e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 Years	cation 10 completed) College (1-4or 5+)	(Give kind life. DO	's Usual Occupation of of work done duri NOT use retired) emaker	n ing most of working	7	Kind of Business/In	dustry
yland	2 should be filed and Mental Hyg Is marked other reumatic event,	To Be C	17. Father's Name (First, Middle, Last) Samuel Weisel				Rose Ste			
	es 1 and 2 should of Health and Men fitem 27 Is marke r other treumatic		19a. Informant's Name/Relationship (Type Rhoda L. Fawcett - 20a. Method of Disposition 1 ☎ Burial 2 □ Cremation 3 □ Re	- Daughter	5225 E		Place, O	Columbia,	or Town, State, Zip Maryland Location - City or To	21044 own, State
Бапптог	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Mo	unt Le	banon	6/27/2		Chapels, le, Maryl	
on,	Physician / Medical state of parallel state of physician and physician and the pridical state of the pridical state of the pridical state of the pridical state of the pridical state of the physician state o	licai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Decays on each line. Congestive He Due to (or as a consequence Chronic Obstr Due to (or as a consequence Chronic Obstr Due to (or as a consequence Chronic Obstr)	art Fa	ilure				Approximate Interval Between Onset and Death
O. BOX 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ect	topic pregnancy her (specify)			23d. Date of delive Month	ery Day Year
cords, F	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con Osteoporosis, Ala				n Part I.		use contribute to the	he cause of death?
Ì	The ate ha	e Completed	25. Was case referred to medical			21	6. Place of Death	24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of 2 No
01 V	hysician: his certific I director.	To Be	eyaminer?	ospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient :	3 DOA Other:	4 Nursing Hom		6 □Other (Specify	ý)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)		28c. Injury at Work? M 1 ☐ Yes	28 2 □ No	d. Describe how in	ury occurred	
2	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Town, Sta		
	ne Hosp 1 24 ho Ne Fune Hetely f	Medicai	29a. Certifier (Check only one) 1	ician: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death oc and/or invest	curred at the time, igation, in my opini	date and place, an on, death occurred	d due to the cause I at the time, date a	(s) and manner as sind place, and due to	tated. the cause(s)
	To the to the comp	Me	29b. Signature and title of certifier			29c. License no D2657			ne 23, 20	
	1		30. Name and seess per Amora		Fernwoo		# 401, B	ethesda,	Maryland	20817
	Sta	ate	31. Date filed (Month, Day, Year)	3 Registrar's Signature	book	2				

			1 _ For	State of Ma	ryland / Dep	artment of F		Mental Hyg	iene	
			Registrar 1. Decedent's Name (First, Middle, La	st)	Ce	runcate of	Dealli	2. Date of Deat	eg. No. 2	5 22913
	Physici		JAMES MERRI		EC			Month	Day Yes	ar IMAID & M
	/Medio		4a. Facility Name (If not institution, giv		LJ	4b. City, Town, o	r Location of Dea	JUNE th	24 200 4c. County of D	
			Peninsula Regional	medical .	Center	50.	11sbury		Nicom	ico
	Funeral Director		5. Social Security Number 6. S 213 22 5634	ex 7. Age 78 78	(In yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent					OCI, 3,	1320 1016	aryland
	arylar show	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	he M	Directo	Maryland Worcest 10e. Street and Number	er	Ocean Pi					1 XYes 2 □ No
	with or a					10f. Zip Code		1	0g. Citizen of What	Country?
	ms 23	era	11 Dockside Ct.	12. Was Decedent B	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (U.S.A. 14. Race - A	merican Indian,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other freumatic event, the Medical Examiner must be mailtied at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 TYes 2 D N If Yes, Give 7 Year or Dates: 1	。WWII	If Yes, specify Cubin	an, Mexican, Puè Specify:	rto Rican, etc.)	Black, W	
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup	pation		16b. Kind of Busine	
215	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-	life.	e kind of work done DO NOT use retired	during most of wo d)	orking		•
	filed wi Hygien other th	Son		2	Print	ter			Printing	
ğ	be fill of oth	Be	17. Father's Name (First, Middle, Last					me (First, Middle, M	,	
Maryland	should be nd Mental marked o	P	Roy Melvin LeGat		405 14.7			della Bro		
Z	d 2 sl th an t7 ls r treur		19a. Informant's Name/Relationship (ural Route Number		
ā,	Health tem 27 tem 27		Elmira D. LeGates 20a. Method of Disposition		20b. Place of Disp	Ockside (osition (Name of		ean Pines	MD 21 20c. Location - City	811 or Town. State
Itimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			matory`or other place nlopen Ci			rankford	
Baltii	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral ervice Licer	·	2	2. Name and Addre	ss of Facility		10902 Oc	ean Gateway
	402 4 4		23a Parti Enter the disease or com	Directions that saused					Berlin,	MD 21811
1			23a. Part1. Enter the disease, if com shock, or heart failure. List only Immediate Cause (Final		_			ic or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	w	LVACIE	Sircer	Υ			hous
	Examiner			b. MITEAL	consequence of):	EAK ON	Luman	· hand	00517A	237.5
	TO WELL	Je.	Sequentially list conditions, it any, reauting to immediate cause. Enter Underlying		consequence of.	2	1	(col for	4 15/0.1	767
	rcuted nd transi	Examiner	Cause (Disease or injury that initiated events	c						
ő,	e execian a	Ë	resulting in death) Last	Due to (or as a	consequence of):					
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9 xo		Ψ 1	IF FEMALE:	23c. If yes, outcome of	f pregnancy					
Bo	The law requires that the death certifule has been signed by the attending lab as should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of Month	delivery Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ine or dealir 5	Other (specify)				
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significant conditions	ontributing to death bu	t not resulting in the t	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w requires been sig should be							1 💇 (e	s 2 🗆 No 3 🗆	Probably 4 DUnknown
000	aw re	Completed						24a. Was ar		autopsy findings available
		E						autops perform 1 □ Yes 2	ned? death	to completion of cause of ? es 2 \sum No
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<u></u>	Physic this car	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier		nt 3 DOA Oth	er: 4 🗆 Nursing I	Home 5 🗆 Reside	nce 6 Other (S	pecify)
ŭ	ding F	ioi	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injun (Month, Day)	Year) 28b. Time (Wor	k?	28d. Describe ho	w injury occurred	
S	death death stor: , the t	icat	2 Accident investigatio 3 Suicide 6 Could not b	e Jan Place of Inju	nt. At home feet at		Yes 2 □ No	Opf Leasting (Ct		0 -17 - 11
2	l or Atten after deat Director:	Certification;	4 - Homicide determined	building, etc.	y - At home, farm, st (Specify)	reet, ractory, onice		City or Town	, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Pt	ysician: To the best o	f my knowledge, dea	th occurred at the tir	ne, date and plac	e, and due to the ca	use(s) and manner	as stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examone)	niner: On the basis of and marner stat	examination and/or in	nvestigation, in my o	pinion, death occ	urred at the time, da	ite and place, and o	lue to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of cartifier	(1		29c. Licens	e number	29	d. Date signed (Mo	onth, Day, Year)
			1 (10	XX		D5	3551		JUNE!	24 2005
2			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)	- , /			•
Ò	1 10+1		James Todd	100 E.	Carroll	St. S	plish	ry ML	2/801	/
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 9	005 32. egistra	VA A	2040		-		24 2005

James M. Legates 213-33-5634

Division of Vital Records, P.O. Box 68760,

		For State	Pleas	State of Ma		d / Depa	artment of	Health and			•	
Physicia	,	Registrar 1. Decedent's Nam	e (First, Middle,	Last)	_	Cei	rtificate of	Death	2. Date of De Month	Reg. No eath Da	2005 y Year	272 John Li
/Medica Examine	1			s Ledwith give street and number)				or Location of Dea	June		2005 County of Deat	
Funeral Director		Berlin I 5. Social Security N 109-14- Usual Residence o	dumber 6820			ast birthday) Yrs.	Berli If Under 1 Year Months Days	If Under 24 Hi		rth a <i>y, Year,</i> 923	Worcest 9. Birtl Co	hplace (State or Foreign untry)
Aaryland f show		10a. State	10b. County	costor	10c. City	, Town or Lo	n Pines					10d. Inside City Limits 1 ☐ Yes 2X No
	Director	MD 10e. Street and Nu	mber	cester		Ocean	10f. Zip Code	4		10g. Ci	tizen of What Co	untry?
urs after	by runeral	10 Fair	ried 2 X Marne	12. Was Decedent Armed Forces?	No		2181 Was Decedent of If Yes, specify Cul 1 ☐ Yes 2√2 No	Hispanic Origin? can, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, White	
within 72 hours lene. 'than "natural', 'he Medical Exe	Completed	(Spec	, , ,	s Education grade completed)	5+)	(Give	dent's Usual Occu kind of work done DO NOT use retin	during most of w	vorking	16b. k	(ind of Business/	Industry
be filed wintal Hygien ed other the sevent, the	De l	12 17. Father's Name	(First, Middle, L	ast)		Stea	ımfitter		ame (First, Middle		Construc G Sumame)	tion
nd 2 should lih and Men 27 Is marke r treumatic	2	James Le 19a. Informant's N Audrey	lame/Relationsh					t and Number or i	Rural Route Numb Ocean F	-		
perms. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than any injury or other treumatic event, the Magone.		20a. Method of Dis	position Cremation 5 Other (Sp	3 □Removal from State ecify)	CE	ace of Dispo emetery, cree te of 1	esition (Name of matory or other pla Heaven (2. Name and Addr	Cem. 6 /	29/2005 he Burb Berlin, 1	Da Da age	gsboro, Funeral	Town, State
bur bur	dical Examiner	2 Partl. Enter shock, or heir shock, or heir smediate Cause disease or condition resulting in death) Sequentially list or if any, leading to it usus. Enter Und Cause (Disease) (Disease) that initiated event resulting in death)	(Final on on on on on on on on on on on on on	a. Due to (or as c. Due to (or as d.	a consequ	lence of):	er the mode of dy	ing, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death CTCUS
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the the state of the s	by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnant Other (specify)	су			23d. Date of deli Month	ivery Day Year
		Part II. Other sign	ificant conditio	ns contributing to death b	out not resu	ulting in the u	inderlying cause g	iven in Part I.		tobacco Yes 2		the cause of death?
	e Completed	05 Was associated							1 Yes	opsy ormed? 22 N	death?	topsy findings available completion of cause of 2 \sum No
ng Ph ifter th	Certification: 10 B	25. Was case referexaminer? 1 Yes 2 7 27. Manner of Dea 1 Natural 2 Accident 3 Suicide	Xe	ot be 28e. Place of In	ury ay Year) jury - At ho	ER/Outpatier 28b. Time o Injury me, farm, st	of 28c. Inju	ther: 4 Nursing ury at ork? □ Yes 2 □ No	Home 5 Res 28d. Describe	how inju	ury occurred	cify) ural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to		4 Homicide 29a. Certifier (Check only)	1 Certifyin	Physician: To the best	tc. (Specify	wledge, deat	h occurred at the	time, date and pla	City or To	e cause(s	s) and manner as	stated.
To the Howithin 24 To the Fu	Medical	29b. Signature and	title of certifier	examiner: On the basis of and manner st	or examinat	lion and/or in	29c. Licer	opinion, death oc	_		ate signed (Month	
N 4+1		3. Name and add	tress of person v	who completed cause of Borodu	death (Item	23a) (Type,		7 Coast		luc	Fen	net Flac
Stat Registra		31. Date filed (Mo.	JUN 2	2005 32. egist	rar's Signa	b A	hode		4	(

			1 - For State Registrer	State of Marylan		artment of I rtificate of		nd Me		ene g. No. 200	5 22015
	Physici /Medic		1. Decedent's Name (First, Middle, Frances Ruth 1						Date of Death Month	27 200	3. Time of Death J
	Examir		4a. Facility Name (If not institution,	•		4b. City, Town,				4c. County of De	
			North Arundel I	iospital 5. Sex 7. Age (In yrs. I	ast hirthday)	Glen If Under 1 Year	Burnie	4 Hrs o	Date of Birth	Anne A	
	Funeral Director		261-47-0679	1□M 2\\ F 91	Yrs.	Months Days		Min. J	(Month, Day,) une 2, 1	914 Vi	irthplace (State or Foreign Country) rginia
	ō		Usual Residence of Decedent							, , , VI	Lgiiia
	arylar show	_	10a. State 10b. County		, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X No
	Ne Mark	Director		rundel Da	avidso						
	with t		10e. Street and Number	. 1 .		10f. Zip Code			10	g. Citizen of What (Country?
	death ms 23	Funeral	673 W. Centr	12. Was Decedent Ever in II	S. 13. V	210 Was Decedent of f Yes, specify Cub		in? (Specif	y Yes or No-	USA 14. Race · An	nerican Indian,
٥	or ite		1 Never Married 2 Marrie		1	fYes, specify Cub 1 □ Yes 2 🛣 No		Puerto Ric	an, etc.)	Black, Wi	
200	within 72 hours after death with the Maryland and. than "natural", or items 23a or 28a-f show ta Masilcal Examinar mant be notified at	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:						Specify: W	
Σ.	"nate	Completed	15. Decedent' (Specify only highest	s Education grade completed)	(Give	tent's Usual Occu kind of work done DO NOT use retire	during most	of working	16	6b. Kind of Busines	s/Industry
7	within ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	3 a)			Orm Ha	
yiand 21215-0036	Hygie other	0	17. Father's Name (First, Middle, L	ast)	Home	cmarci	18. Mother	's Name <i>(F</i>	irst, Middle, Ma	Own Hor aiden Sumame)	ie
lar I	uld be Jental irked o	To B	Frank L. Owen				Laur	ra M.	O'Deli		
Mar	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Manth Hygens. If item 27 is marked other than 'natural; or items 23a or 28a-f show it it item 27 is marked other than 'natural; or item inval to notified at or other treumatic event, it a Marical Examination inval to notified at		19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Stree	t and Number	or Rural R	oute Number, (City or Town, State	Zip Code)
2 <u>`</u>	and and sealth m 27 m		John M. Miller				tral Av			nville, N	
0	ges 1 It of H If ite or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	Romoval from State	emetery, crer	sition (Name of natory or other pla		Date		oc. Location - City o	
saltimore,	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Sp21. Signature of Funeral Service L		dens	Memoria:	1 //	/1/200		avidsonvi	
n a	permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service L	Censee	1.6	5000 Anna	ess of Facility	Robe	rt E. E	vans Fune	eral Home
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that caused the death							Approximate Interval Between
	Physician personned diud bhysician and modical Examiner see as the pruial-itansit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gastvous Due to (or as a consequence) Due to (or as a consequence) C. Due to (or as a consequence)	uence of):	inal I	Blee	dung			Onset and Death
BOX PR	w requires that the death certificate been signed by the attending phys should be detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	cy -			23d. Date of d	elivery Day Year
,	tt the c by the tacher		9 Unknown	9□ Unknown							
oras, r	The law requires that the te has been signed by thouge 2 should be detache	ed by P	Part II. Other significant condition	s contributing to death but not resu	ilting in the ui	nderlying cause gr	ven in Part I.			_	to the cause of death? Probably 4 Unknown
e C C	faw re as be 2 sho	ompleted							24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
		Com							performe	d? death?	
VIII	Physicien: Th this certificete ral director, pag	Be (25. Was case referred to medical examiner?					of Death (C	heck only one)		
0	Ø ⊅	2	1 ☐ Yes 2 ☐ No 27. May er of Death	Hospital: 1 Inpatient 2 1	ER/Outpatien	1 3LI DOM				ce 6 Other (Sp	ecify)
0	ding Ph h. After th funeral	tion	1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury	Wo	nryat ork?]Yes 2 ∐ No		. Describe now	injury occurred	
) <u> </u>	or Attenation deat Director: in by the	ertification:	2 Accident investigation of Could not determine the Accident investigation investigati	ot be	me, farm, str				Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical S	Physician: To the best of my know xaminer: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tivestigation, in my	ime, date and opinion, death	place, and	due to the cau at the time, date	se(s) and manner as a and place, and du	as stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	£ 14) D	M MI), 29c Licen	se number 5			I. Date signed (Mor	oth, Day, Year)
			30. Name and address of person y	the completed cause of death from		Print) OS pA	al Dr	ive	Glen	Burnie	MD. 21061
	Sta Registr		31. Date filed (Month, Day, Year)	32. Rystrar's Signat	ture	harth .					*2,45

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2005 **Physician** July Monica Morris 6 1:30pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25236 Military Road Cascade Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1953 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2 T F Yrs. 083/38/1216 52 Director January 30, Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Cascade 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? or Items 23e 25236 Military Road 21719 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: by 3 Widowed 4 Divorced "natural", White leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiena. ant: If item 27 Is marked other than ' Compi Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LaRue Croman 2 Mary Ann Donick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Morris (Husband) 25236 Military Road Cascade, Maryland 21719 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any Injury or ot once. □ Burial 2 X Cremation 3 □ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory July 8,2005 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Mo1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 AVIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final Physician MENOCARCINOHA 48AL1 resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed: 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 No this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 1.XNatural 5 Pending 24 hours after death. Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 the 29b. Signature and title of certifier MEU CHASCE 29c. License number 29d. Date signed (Month, Day, Year) D10587 1.0

Registrar
DHMH 17 Rev 1/2001

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of AFDERICK CO.

516

REDERICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2005

SMITH,

31. Date filed (Month, Day, Year)

Itoslice

32. Resistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James Julius Martinelli 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 PA 6. Sex 8. Date of Birth (Month, Day, Year) Jan 23, 1923 **Funeral** Months Days Hours 1(XM 2□ F 82 Yrs. 193-16-6268 Director Usuel Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director PA Franklin Antrim TWP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15367 Martinelli Drive **1**7263 USA Completed by Funeral filed within 72 hours after death tems. 12. Was Decedent Ever in U.S. Armed Forces?

1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 XNo Specify: Specify. White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, The Media once. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Truck mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luigi Martinelli Rosa Leopardi ౖ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Martinelli P O Box 434 State Line, Pa 17263 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Jul 8, 2005 Greencastle, PA 17225 22. Name and Address of Facility Miller-Bowersox Funeral Home 21. Signature of Funeral Service Licensee 521 S. Washington St. Greencastle, PA 17225 Paretta 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician oronary /Medical Due to (or as a consequence of) Examiner choon; Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner Physician: The law requires that the death certificate be executed the burial-transit Hyper Due to (or as a consequence of): P.O. Box 68760. physician IF FEMALE: for use If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the be detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital on Attending 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opal URSHE FARID 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

				State of Marylan				-	•	
			1 - For State Registrer	otate or marytan		ificate of Deat		, ,	No.2005	22010
			1. Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
	Physici /Medio		Clifton Benjamin	Martin Jr.				June 27	• 2005 Year	11:30AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location	on of Death		4c. County of Death	
			Casey House	17.4-4		Rockville	dos 24 Hsg. Ta	1	Montgomery	
	Funeral Director		5. Social Security Number 6. Se 15 15 15 15 15 15 15 15 15 15 15 15 15	7M 2□ E		If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8.	Date of Birth (Month, Day, Ye June 19,	^{9. Birthp} Coun 1944 Mary	lace (State or Foreign toy)
			Usual Residence of Decedent		, <u> </u>			June 17,	1744 1141 9	Tana
	ırylan show	_	10a. State 10b. County	10c. City	y, Town or Loca	ition			1	Od. Inside City Limits
	8a-fs	cto	Maryland Baltimore	e Woo	dlawn					1 Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code			Citizen of What Coun	try?
	eath rs 23	Funeral Director	2030 Wildlife Driv	12. Was Decedent Ever in U.	S 13 W	21244	Origin? (Specif	US v Yas or No-	A 14. Race - Americ	an Indian
(0	r Iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	lf Y	as Decedent of Hispanic 'es, specify Cuban, Mexi		an, etc.)	Black, White,	
8	rel', o	by	3 ☐ Widowed 4XX Pivorced	If Yes, Give Year or Dates:	1]Yes 2⊠No <i>Spec</i>	rify:		Specify:	rican rican
5-0	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "neturel", or items 23a or 28a-f show event, the Medical Everting must be natified at	Completed by	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Decede	nt's Usual Occupation nd of work done during m NOT use retired)	nost of working	161	o. Kind of Business/Inc	
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)					+4 D+	
d 2	filed Hygid Sther ant, II	e Co	17. Father's Name (First, Middle, Last)	4	busine	ess Owner	other's Name (F	First, Middle, Mai	tique Rest	oracion
<u>a</u>	ld be lental ked c	To Be	Clifton Benjamin N	Martin Sr.		Jul	lia Ora	Bell		
Maryland 21215-0036	shou s mai		19a. Informant's Name/Relationship (T)		19b. Mailing	Address (Street and Nur	mber or Rural R	oute Number, C	ity or Town, State, Zip	Code) V5T2N9
	and 2 ealth n 27 i		Tonya Alicia Mart:		1032 E	. 14th Ave.	Vancou	iver, Br	itish Colu	mbia
ore	ges 1 t of H If itea		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	lace of Disposit emetery, crema	ion (Name of tory or other place)	June		c. Location - City or To	wn, State
Baltimore,	t. Partmen rtant: njury		' 4 □Donation 5 □Other (Specify)			Crematory	2005		enton, Mar	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show amy bright or other treumatic event, the Medical Exprinter must be notified at ORGs.		21. Signature of Funeral Service Licens	1111	Go i 251 Bev	Name and Address of Fa Ing Home Cre verly L. Hec	emation krotte	Service P.A. C	P.O. Box larksville	784 , MD 21029
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	ications that caused the death ne cause on each line.	n. Do not enter	the mode of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Metastatic P	rostate	Cancer				Onset and Death Years
	/Medical Examiner		resulting in deathry	Due to (or as a consequ	uence of):					
		er	Sequentially list conditions, if any, leading to finite ordate cause. Enter Underlying Cause (Disease or injury that in its descent of the cause of	b. Dire to (or as a sonsequ	ienes of):					
	ate be executed nysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6						
o,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	ate bu	dical		d						
× 68	The law requires that the death certificat lie has been signed by the attending phy bage 2 should be detached for use as th	/Med	IF FEMALE:	23c. If yes, outcome of pregna	nov					
Box	atten atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □E	ctopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
o.	at the de by the a tached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
رث	igned b	by P	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the und	erlying cause given in Pa	irt I.	23e. Did tobac	co use contribute to the	e cause of death?
ğ	w require been sig should b							1 🗌 Yes	2 X No 3 □ Proba	ibly 4 □Unknown
Records,	e law r has be je 2 sh	Completed						24a. Was an autopsy	24b. Were autop	sy findings available
<u>=</u>		Con						performed 1 ☐ Yes 2 🔀	l? death?	
Vita	ysicien: This certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.0	ace of Death (C			
ot	Attending Physicien: r death. sctor: After this certificiny the funeral director.	: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 4		5 Residence Describe how i	e 6X10ther (Specify	Hospice
on	ith: : After thi e funeral	atior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work? M 1 □ Yes 2			.,,	
Division of	or Attendater death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stree	t, factory, office	28f.	Location (Stree City or Town, S	t and Number or Rural	Route Number,
ā	rs afte	Ceri		building, etc. (Specify				Only of Town, 3	1410)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death o tion and/or inve	occurred at the time, date stigation, in my opinion, d	and place, and leath occurred	due to the caus at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License numbe	er e e e e e e e e e e e e e e e e e e	29d.	Date signed (Month, D	Day, Year)
			I Chile ly	yel-		D42452		Ju	ne 27, 200	5
			30. Name and address of person who			int)				
			Chitra Rajagopal I	M.D. 6001 Munc	easter N	Mill Rd. Roc	kville,	, MD 208	55	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 2	005 Signat	Dr A	ale				

		State Registrar 1. Decedent's Name (First, Middle, Li	ist)		061	ance	ate of	Doan		2, Date of Dea	Reg. No	2005	7 Time Olokath
icia	n	Gerald E. McCa:								Month June 2	Day 4		12:30 ^p M
dica nine		4a. Facility Name (If not institution, gi				4b. Cit	ty, Town, o	r Location	of Death	June 2		County of Dea	
		Montgomery Gene	eral Hospi	tal			01	ney				Montgo	merv
al			Sex 7. Ag		last birthday)	If Und Month	er 1 Year S Days	If Unde Hours	Min.	8. Date of Birt (Month, Day	v. Year)	9. Bir	thplace (State or Foreign ountry)
r	-	042-12-3750 Usual Residence of Decedent	IMAM ZUF	82	Yrs.		<u></u>			June 5,	192	23 Co:	nnécticut
	-	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	į	Maryland Monte	gomery	S	Silver	Spr	ing						1 ☐ Yes 2 🖾 No
	Director	10e. Street and Number					Zip Code				10g. Cit	izen of What Co	ountry?
	la	3423 S. Leisure						209				US	
	by Funeral	11. Marital Status	12. Was Decedent Armed Forces	•	.S. 13.	Was Dec	cedent of H pecify Cubi	lispanic O an, Mexica	rigin? (Sp in, Puerto	ecify Yes or No- Rican, etc.)		 Race - Ame Black, Whi 	
ľ	Ž	1 Never Married 2 Married 3 Widowed 4 Divorced	1 K Yes 2 ☐ If Yes, Give Year or Dates:	NO WWI	I	1 🗆 Yes	2 X No	Specify	:			Specify: Wh	ite
		15. Decedent's E	ducation		16a. Dece	dent's U	sual Occup	ation			16b. K	ind of Business	/Industry
	pg-	(Specify only highest gi	College (1-4or	5+)	life.	DO NOT	work done use retire	during mo d)	st of work	ing			
	Completed		4		Ele	ctr	ical					S. Gov	ernment
	Be	17. Father's Name (First, Middle, Las	")							e (First, Middle,	Maiden	Sumame)	
ı	0	Fred McCarthy 19a. Informant's Name/Relationship	(Type Print)		10b Mailie	on Adden	no /Ctrant	L		t Drew	- Cinu	Town Chata	7:- C
Ji.		Dorothy B. McCa:				-					-		<i>Zip Code</i> MD 20 906 F ,Silver Spri n
	1	20a. Method of Disposition		20b. P	Place of Dispo semetery, crer					e 26,		ocation - City or	
		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Spec			ropolita						Alex	andria.	. Virginia
ė	ı	21. Signature of Funeral Service Lice	• •						i ^{ty} i ng	_			
3		J. Ken Skiles			50	00 Ur	niver	sity	Blvd	, W, Si	lver	Spring	g,MD 20901
		23a. Pagl. Enter the disease, or cor shock, or heart failure. List only	nplications that cause one cause on each I	d the death	h. Do not ent	er the m	ode of dyir	ng, such as	s cardiac	or respiratory ar	rest,		Approximate Interval Between
ı		Immediate Cause (Final disease or condition	Advanc										Onset and Death
ı		resulting in death)	Due to (or as		uence of):								
ı	_	Sequentially list conditions,	Pneumon										
1	n lue	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury	Due to (or as Conges			Fail	Lure						
I.	Examiner	that initiated events resulting in death) Last	c. Due to (or as										
1	call	(d										
1	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic	pregnancy	,			1	23d. Date of de	,
	SICI	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	4☐Pregnant a 9☐ Unknown			Other (-			Month	Day Year
i	Phy.	9 ☐ Unknown Part II. Other significant conditions	contributing to death t	out not roo	ulting in the	n doch in a		on in Bort		220 Did to	bassa	ino contributo t	the cause of death?
	۵	Coronary Artery		2011101193	aiting in the u	noonying	J Cause giv	-					robably 4 Dunknown
	etec									24a. Was			
П	Completed						<u> </u>			autop perfor	SV	prior to death?	utopsy findings available completion of cause of
		25. Was case referred to medical	T					OR Dine	a of Door	1 ☐ Yes		1 🗆 Yes	2 □ No
1	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆	ER/Outpatier	 nt 3□ [DOA Oth	-		me 5 Resid		6 DOther (Spe	cifu)
ľ	- ino	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of Injury	-	28c. Injur Wor	y at		28d. Describe h			ony)
	atio	1 X Natural 5 ☐ Pending investigate	n	y rour	injury	М		Yes 2]No				
1	Certificati	3 ☐ Suicide 6 ☐ Could not determined		jury - At ho	ome, farm, str	eet, facto	ory, office	2		28f. Location (S City or Tow			ural Route Number,
		¥							- 1				
	edical	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of	or examina	wledge, deatl ition and/or in	h occurre vestigation	ed at the tir on, in my o	me, date a pinion, de	nd place, ath occurr	and due to the cred at the time, c	ause(s) date and	and manner as place, and due	s stated. a to the cause(s)
		29b. Signature and title of certifier	and manner si	ated.		2	9c. Licens	e number			29d. Dat	te signed (Mont	h, Day, Year)
		· gra	26					61696				June 27	
	-	30. Name and address of person who	completed cause of	death (Item	n 23a) (Type	Print						Julie 2	, 2000
					/ (· ypa,								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

	- Registr
	1. Decedent
sician	PAULI

Reg. No. 200 2. Date of Death Day 2005 June 24,

4c. County of Death

10g. Citizen of What Country?

Prince George's

Nigeria

9:43A. M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Phy /Medical **Examiner**

Funeral Director

with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show may injury or other traumatic event, the Madical Examinational Le radified at once. filed within 72 hours after death 1 Hygiene.

Direct

Funeral

þ

Physician /Medical Examiner

> use as the burial-transit attending physician the has After t the within 24 hours after death To the Funeral Director:

The law requires that the death certificate be executed

Hospital or Attending Physician:

2

Division of Vital Records, P.O. Box 68760,

Completed Be (Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant þ Completed Be 25. Was case referred to medical Certification; To

in the past 12 months?
1 Yes 2 No

1 Yes 2 XNo

Manner of Death

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

's Name (First, Middle, Last) 5. Social Security Number none Usual Residence of Decedent Maryland 10e. Street and Number 11204 Cedar Lane 11. Marital Status 1 Never Married 2 Married 3 ♥ Widowed 4 □ Divorced Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Victor 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Certificate of Death AKUNNA ODINKEMELU 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 1 ☐ M 2 🖫 F 70 Yrs. 10c. City, Town or Location Prince George's Beltsville 10f. Zip Code 20705 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1 - 4Dietitian Nwaokoro 19a. Informant's Name/Relationship (Type, Print) Theodora Okereke -daughter

Nigeria Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
African Specify: American 16b. Kind of Business/Industry

8. Date of Birth (Month, Day, Year) June 25, 1934

Health 18. Mother's Name (First, Middle, Maiden Surname) Nwaokoro

4400 Powder Mill Road Beltsville, Maryland 20705

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11204 Cedar Lane Beltsville, Maryland 20705

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Family Compound 7/2/2005

Avo-Idemili Imo State Nigeria Donald V. Borgwardt Funeral Home, PA

Approximate Interval Between Onset and Death

2months

2weeks

3months

Metastatic Ovarian Cancer Due to (or as a consequence of): Hepato Renal Syndrome Due to (or as a consequence of): Cardiomyopathy

Due to (or as a consequence of):

Live birth 2 Fetal death

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient

PITYSICIAN

28a. Date of Injury (Month, Day Year)

4☐Pregnant at time of death

23c. If yes, outcome of pregnancy

23d. Date of delivery 3 Ectopic pregnancy Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure; atrial fibrillation

28b. Time of

Injury

5 Other (specify)

3 DOA

М

1 Yes 2X No autopsy performed? Yes 2 XNo 1 Yes

3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

23e. Did tobacco use contribute to the cause of death?

2 🗆 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Ale of certifier 29c. License number 29d. Date signed (Month, Day, Year) RTIENDING D57216

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL BANKS

7300 VAN DUSED 120 LANDED

State Registrar

Medical

31. Date filed (Month, Day, Year) 2 8 2005

5 Pending

32 Registrar's Signature

For	State of Maryland / Department of Health and M
State Registrar	Certificate of Death

			1 - For State Registrar	State of Ma		partment of Fertificate of			giene Reg. No.	2000	
	Physici /Medic		1. Decedent's Name (First, Middle, L Stephen	Peet				2. Date of De Month June	Day	ZUU5 Year Zeros	3. Zim Por Gestin
	Examir	ner	4a. Facility Name (If not institution, guniversity of Mary) 5. Social Security Number 6.	and Medical	Center e (In yrs. last birthda)	Bal-	r Location of Death timere If Under 24 Hrs.			County of Death	
	Funeral Director		132-54-9846 Usual Residence of Decedent	1 ∑ M 2□ F	47 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Mar. 1	0, 19	958 Sitting	plece (State or Foreign ntry) NY
	Maryland f show	tor	10a. State 10b. County	e Georges	10c. City, Town or	Location Upper Ma	rlboro				10d. Inside City Limits 1 ☐ Yes 2X No
	h with the	al Director	10e. Street and Number 17300 Clagett I	Landing Road	đ	10f. Zip Code	0774		10g. Citize	en of What Cou USA	ntry?
5-0036	within 72 hours after death with the Maryland ane. than "natural", or itams 23a or 28a-f show to Mudical Exertine: ast be notified at	by Funeral	11. Marital Status 1 ★ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 1 Yes 2 Yes If Yes, Give Year or Dates:		B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White Specify: W	
0-612	thin 72 ho e. an "natur. Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	during most of wor d)			d of Business/Ir • Andrew	w by the
and 21	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, La Richard Peet	5+ st)	Direc	ctor of Mu	sic & Li 18. Mother's Nam Susan N	ne (First, Middle		*	lic Church
, Maryland	d 2 shouh and N is mai	2	19a. Informant's Name/Relationship Teodoro E. GeLa			iling Address (Street 00 Claget	and Number or Ru	ral Route Numb			oro, MD
altimore,	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of the Control	cify)	Metro	ematory or other place Crematory	, ou	ne 23, 2005	Bal	ation - City or T Ltimore,	MD
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Lie	E Allen	ı	22. Name and Addre Barranco 495 Gov.	& Sons, I Ritchie I	A. Sev Wy, Sev	erna erna	Park Fu Park, M	neral Home ID 21146
	Physician /Medical		23a. Part . Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	emplications that caused ally one cause on each lin	10.	nter the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions.	b. Ostuct	a consequence of):	apula					10 years
8760,	cate be executed physician and the burial-transit	Examin	If any, leading to intrinduale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Accepted to for as:	a consequence of):	Ture					3 weeks
9		Medical	IF FEMALE:	0.		W.F.W.					
O. Box	at the death certifi by the attending tached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	,		23	3d. Date of deliv Month	ery Day Year
1	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	s contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did t		/	the cause of death?
I Records,	The ate h	Completed	Morbid obesity							24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available impletion of cause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	ont 2 ☐ ER/Outpati	ent 3CIDOA Oth	26. Place of Dea				
Division of	fte ne	atlon; To	27. Manner of Death Natural 5 Pending Accident investigate	28a. Date of Injur (Month, Day	ry 28b. Time	of 28c. Injur	y at	ome 5 Resi 28d. Describe			fy)
DIVIS	tal or Attending rs after death. al Director: After ed in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
	To the Hospital or within 24 hours aff To the Funeral Discompletely filled in	edical	29a. Certifier \ \(\sum \ Certifying \ (Check only \ one) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physician: To the best of caminer: On the basis of and manner sta	examination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
	To ti withi. To ti comp	Me	29b. Signature and title of certifier	1 no		29c. Licens				signed (Month,	Day, Year) 2005
			30. Name and address of person while strey Liu, Mi		leath (Item 23a) (Type 12 Greene	e, Print)	18600 altimore,	MD	2120	1	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 0	2005 32. Pogistra	ais signature	house					
DH	IMH 17 Rev 1/2	2001			- 7			====			

ORIGINAL

			For State Registrar 1. Decedent's Name (First, Middle, i		arylan		artment of tificate of		and Mental I	Reg. N	000	5 22952
1	nysicia Medic kamin	an al		VIN POWNAI	<u> </u>	- : / /	4b. City, Town,	or Location	Month June	30 4	2005 c. County of D	2040 M
	neral ector		234-40-3424		0 SP e (In yrs. 1. 79	TTAL ast birthday) Yrs.	If Under 1 Yea		LAND 124 Hrs. 8. Date of (Month) Min. March			Birthplace (State or Foreign Country)
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, Therms 23e or 28e-f show	otified at	ector	Usual Residence of Decedent 10a. State 10b. County WV Hampsh	ire		, Town or Lo ringfi	e1d					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with t	rmust be n	Funeral Director	PO BOX 24 11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \		763	rigin? (Specify Yes on, Puerto Rican, etc.			mencan Indian,
0036 hours after	al Examines	d by Fur	1 M Never Married 2 Married 3 Widowed 4 □ Divorced	If Yes, Give 'Year or Dates:	No		1 ☐ Yes 2 📉 No	o Specify			Specify:	White, etc. White
d 21215-0036 filed within 72 hours af Hygiene.	injury or other treumetic event, the Mudical Examiner must be notified at 9.	Completed by	15. Decedent's (Specify only highest of Specify only highest of Specify (0-12)		5+)	(Give life. l	lent's Usual Occi kind of work don DO NOT use retir	e during mos red) n Rese	arch	Ma	Kind of Busine	
Maryland 10 2 should be file 11th and Mental Hy 27 is marked oth	metic event	To Be	 Father's Name (First, Middle, La Joseph I. Pownal Informant's Name/Relationship 	1		19h Mailir	ng Address (Street	Jos	er's Name (First, Mid ephine Wa, er or Rural Route Nu	goner		a Zin Coda)
ore, Ma	r other treu		John W. Corbin, 20a. Method of Disposition 20 Burial 2 Cremation 3	Jr.	20b. PI	PO ace of Dispo	BOX 141 sition (Name of natory or other pi	Spri	ngfield,	WV 2	6763	or Town, State
Baltimore, Maperine, Pages 1 and 2 Department of Health a	eny injury o once.	Ì	*4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice	cify)	Spr:	22			7/6/05 shaffer Romney,	-Warn	ringfie ick Fur 26757	eld, WV neral Nome
Physi /Med	cian dical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused by one cause on each line. a. SEPS Due to (or as	i S	. Do not ent					20131	Approximate Interval Between Onset and Death
8760, \checkmark sate be executed whysician and	ial-transit	dical Examiner	Sequentially list conditions, if any, leading to unmodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. B CEC Due to (or as c. Due to (or as	a sunsequ	ense oi).	itom A					3 YEM-S
Box 6 death certific		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan	су			23d. Date of Month	delivery Day Year
cords, P.O v requires that the	peq	þ	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the ur	nderlying cause g	rven in Part				e to the cause of death? Probably 4 Unknown
O 3 4		Completed	05 1800 000 000 000 000 000 000 000 000 00						1 \(\) Ye		prior death	
6 9	funeral director, page 2	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigations	Hospital: 1 Impatie	ry	ER/Outpatien 28b. Time of Injury	28c. Inj	ther: 4 🗆 Ni		Residence	6 Other (S	Specify)
Division tel or Attending rs after death.	completely filled in by the funeral	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 290 Place of Init	ury - At ho c. (Specify	me, farm, stre			28f. Locatio	on (Street a Town, Stat	and Number or te)	Rural Route Number,
To the Hospitel or within 24 hours after To the Funerel Dir	mpletely fill	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex 29b. Signature and title of certifier	Physician: To the best aminer: On the basis of and manner sta	f examinat	vledge, death ion and/or inv	vestigation, in my	time, date ar opinion, dea	nd place, and due to ath occurred at the time	me, date ar	nd place, and o	as stated. due to the cause(s)
	,		30. N e and address of an wh	C Wans	eath (Item	23a) (Type,	74	205	7	Jui	LY 1 .	2005
	Sta egistra		DR. GREGG D	onaldson	VC	la Se	StON DA	Rive,	Cumber	lan	d MD	21502

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar per dr./tly 6/20/2005 Reg. No per dr./tlv 6/29/2005 2. Date of Death June 24 Month Pay Year 1. Decedent's Name (First, Middle, Last) 2005 20 **Physician** 215 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BENERAL GOME OLNE MONTGOMERY ONT 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 M 379-14-048 Usual Residence of Decedent Yrs. Director Maryland 10d. In side City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 KNo Director MD MONTGOHER SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö COURT U. S. A itams 23a HISWICK 36 34 death Completed by Funeral permit. Pagas 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If ten 27 is marked other them ony injury or other treummit 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 INO Specify: Specify: WHITE 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY SECRETAR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BRI 2 BRICE SALLY HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PODE SVILLE MS 20c. Location - City or Town, State PARSLE Y-SON 19005 HEMPSTONE JOHN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State REDERICK CREMATERY 6/26/05 FREDERICK ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME 20838 BARNESVILLE, MD BOX 86 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (C) nima Priysician Win) disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caucs. Enter Unuallying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be axecuted attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4□ Pregnant at time of death 5 Other (specify) P.0. been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes 2 No 1 Tyes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6

State Registrar 30. Name and address of person who opri

31. Date filed (Month, 194 NYez)

0

pleted cause of death (Item 23a) (Type, Print)

4

32) Rafistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** A M 25, 2:15 2005 June VERA /Medical BRIGGS PHILLIPS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

May 4, 1908 Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1□ M 2√F 97 Yrs. Indiana 315-34-8018 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examinar must be notified at 1√ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 911 Motter Place U.S.A. Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Nidowed 4 Divorced White Year or Dates "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Importent: If tiem 27 is marked other than "na any injury or other treumatic event and once." (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William A. Briggs Rosa Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Cady (Granddaughter) 911 Motter Place, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 6/28/2005 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service License ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. Tu 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final auto anewysn Physician Cupturel disease or condition resulting in death) /Medical Du no (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events iding physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the s Yes 2 70 Division of Vital Records, P.O. 9 Unknown 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: filled in by the 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral I Fo the Hospital 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 036496 ens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. 9Th St; Frederick, Md. 21701 16neis 31. Date filed (Month, Day, Year) rar's Signature 32. Req State 2005 Registrar

			For State	State of Marylar		artment of H		_		
			Registrar 1. Decedent's Name (First, Middle, Last)			tineate or i	Death	2. Date of De	ath 200	5 37 imported 5
	Physici		Mary Tar	re Page	1			June	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dea		4c. County of De	
			412 West B Str	-eet		Bruns	wick		Frede	rick
	Funeral		5. Social Security Number 6. Sex	-53-	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bird	th v, Year) 9. E	Birthplace (State or Foreign Country) 1timore, MD
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	land		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	to	MD Frederic	k F	Brunswi	ck				1x Yes 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Cîtizen of What	Country?
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	ems er.	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No	- 14. Race - Ar Black, W	merican Indian,
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0	hour fure	ed b	15. Decedent's Educ	Year or Dates:	16a Doce	dent's Usual Occup	ation		16b. Kind of Busine	no/leducate.
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212	d with glene or tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Reta	il Sales			Departmen	t Store
g	at Hygen of the vent,	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
yla	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "neturel", or items 23e or 28e-1 show termetic event, it is Modical Examiner manken hilling at	To I	Melvin Preston Who				Emma Ma	ay Shanks	5	
Itimore, Maryland 21215-0036	2 sh and 1 s m		19a. Informant's Name/Relationship (Type						er, City or Town, State	
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စ်	Pages nent of ant: If it		1 ☐ Burial 2 🗷 Cremation 3 ☐ R			sition (Name of matory or other place vn Cremat				
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)			KIN		and	DY	1/8	66:	June 21	, 2005
(7		30. Name and address of person who co	impleted cause of death (Ite	эт 23а) (Туре,	Print)	7			, 2005 1702
	0		31. Date filed (Month, Day, Year)	32. Registras Sign	as Voi	mon on	ne tre	derick	m) 2	1+02
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			State of Maryland / De	partment of Health and Mertificate of Death	Mental Hyg	_	000=4						
	Physici	an	Decedent's Name (First, Middle, Last) Edmond Pachner	Juniodio oi Dodiii	2. Date of Dea	ath Day Year	3. Time of Death						
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death Bethesda	June 2	4c. County of Death Montgome							
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 072-09-6240 1℃ M 2□F 89 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, Day April	h 9 Birth	place (State or Foreign intry) New York						
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	3e or 28	I Dire	10e. Street and Number 10607 St. Paul Street	10f. Zip Code 20895		10g. Citizen of What Cou	intry?						
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Sinch of Health and Mental Hygiene. Sinch of Health and Mental Hygiene. Sinch of the retematic event, the Medical Event and must be notified at Once.	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married Married 1 Pes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2ੴNo Specify:	ecify Yes or No- Rican, etc.)	14. Race · Amer Black, White Specify: Whi	etc.						
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	alth and h			iling Address (Street and Number or Rura 07 St. Paul Street									
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Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins 500 University Blvd	Funera	l Home Inc Silver Sprin	ng, MD 2090						
Į.	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximation of the mode of dying, such as cardiac or respiratory arrest, Interval E Onset and Cause (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final disease) Immediate (Final di										
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	,		30. Name and address of person who completed cause of death (Item 23a) (Type CAOL I. W. A. ROCK (No. 1) (The Cook of the Cook		me los	51							
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 2005 Registrar's Signature	relie		-							

death with the Maryland

28e-f show

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or items 23e

injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 ia marked other than "natural", or ite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical **Examiner**

Bny

The law requires that the death certificate be executed physician and s the burial-transit ģ

Box 68760.

P.O.

Records,

of Vital

Division

To the Hospitel or Attending Physicien:

within 24 hours a To the Funerel [

Examine Completed by Physician/Medical page 2 s after death.

Director: After this certific
I in by the funeral director, Be 2 Certification: Medical

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy rmed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 Yes 2 No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and

29c. License number

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Month

2 No

9. Birthplace

White

Pennsylvania

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

1 Yes 2 No

D0050362

July 7, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smithsburg Family Practice Vincent A. Cantone MD 22911 Jefferson Blvd. Smithsburg, Maryland 21783

12525 Bradbury Ave. Smithsburg, Maryland 21783

31. Date filed (Month, Day, Year) State 3 2005 Registrar

29a. Certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Thomas J. Richie _P ^M June 14 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forestville Health & Rehab. Ctr. District Heights Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F Director 577-28-6622 84 15, 1921 South Carolina Apr. Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Items 23e or 28e-f show the Madical Examiner must be notified at 1 XYes 2 No Director Maryland | Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2419 Ramblewood Dr. 20747 United States filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 10th Truck Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown traumatic Mariah Richie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or othar trau once. 4736 Benning Rd., S.E. #104 Wash., DC Kay Richey-Johnson/Cousin 20019 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/27/05 * 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, MD 21. Signatur of Fundral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Er let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau. (Final disease or con it on resulting in death) Physician Cardiopulmonary failure /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attanding Physicien: The law requires that the death certificate be executed burial-transit Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physiclan/Medical Hypertension the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0 be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 Onknown Blind 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 24 No 1 Yes 2 🗌 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral t

completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06-17-2005 D 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad. M.D. 1328 Southern Ave., S.E. #310 Wash., DC 20032 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 9 2005 Registrar

			For State	State of Ma	-	epartment of Certificate of		nd Mental Hy	giene	
	[□] Physici	an	1. Decedent's Name (First, Middle,	Last)	1	Serincate of	Deam	2. Date of De. Month	Reg. No. 2 0	Vear S. S. P. M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)	d50n	4b. City, Town,	or Location of	Death Dune	4c. County of	005 0150 m
			7 - 70	ration	Road	Shall of Under 1 Year	aro +	own		comico
	Funeral Director		5. Social Security Number / 214-36-7230	5. Sex 7. Ag 1 ☐ M 2 🕱 F	e (In yrs. last birth 67 Y	Months Days		4 Hrs. 8. Date of Birl Min. (Month, Da 09/01	y, Year) 137	9. Birthplace (State or Foreign Country) Maryland
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryla	to	MD Wicon	nico		narptown				1 ☐ Yes 2 ☐ No
	h with the 23a or 28e	Funeral Director	10e. Street and Number 702 Corporati	ion Road		10f. Žip Code	2186	1	10g. Citizen of W	hat Country? States
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show ifted Examana must be crofiffed at	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cult 1 Yes 2 X No		n? (Specify Yes or No Puerto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
15-0	72 hours "naturel",	eted	15. Decedent's (Specify only highest		1 1	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	during most o	of working	16b. Kind of Bus	iness/Industry
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nd	be filed Ital Hygi Ital other event, t	Be	17. Father's Name (First, Middle, La	ast)				s Name (First, Middle,)
Maryland	2 should be filed and Mental Hygid is marked other eumetic event, it	ဥ	Otis Marine 19a. Informant's Name/Relationshi	in (Type Print) C no.1	100 10h	Mailing Address (Stree		nita Todo		Photo Tin Code)
	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 is marked other then "natur other treumetic event, the Medical		Charles Rich	-		2 Corpora	te Rd	., Sharp	town, M	D 21861
Baltimore,	00-==		20a. Method of Disposition 1X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery	Disposition (Name of , crematory or other pla Crest Cen		Date 6/09/05		ity or Town, State 1sburg, MD
Balti	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Li	- Gskow	/	22. Name and Addr 216 N. M	ess of Facility	Framptom t., Feder	Funera ralsbur	1 Home, P.A. g, MD 21632
	Pnysician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that caused only one cause on each lin	the death. Do no	et enter the mode of dy	ing, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between nset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	·):				- Cyrren
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence o	ŗ.				
8760,	be executed sician and burial-transit	al Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence o):				
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.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	Э		23d. Date Mont	of delivery h Day Year
Ω.	w requires that t been signed by should be detar	by	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying cause g	ven in Part I.	23e. Did to	~	oute to the cause of death? B Probably 4 Unknown
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Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patient 3 DOA	hon	f Death (Check only o	ine) dence 6 ∏Other	(Canaita)
υot		-	27. Manner of Death	28a. Date of Inju	ry 28b. Ti	me of 28c. Inju	the state of the state of the state of		now injury occurre	1-177
Division	Attending r death. ector: After by the fune	catic	2 Accident investigation inves	ation of he		M 1	Yes 2□No	_		
Divi	or Attendation of Director:	Certification:	4 Homicide determin	building, et	ury - At nome, tari c. (Specify)	π, street, factory, office		City or Tox	oreet and Number vn, State)	r or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deall to the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Medical E	Physician: To the best xaminer: On the basis of and manner sta	examination and	death occurred at the t for investigation, in my	ime, date and opinion, death	place, and due to the occurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the I	Me	29b. Signature and title of certifier	20/1	10.11	29c. Licen	se number	78	29d. Date signed	(Month, Day, Year)
,			" while	/ Chl	Y VVK		267	-/1	6-9	-05
			DAVIDE. Course	Mo Completed cause of d	eath (Item 23a) (T	PILE P.O.	Box 17	133 Sal	lisber 1	1-05 MD 2/862
••	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Fegistr	ar's Signature	frest)			Ö	

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 **Physician** JUNE 24, KATARINA 11:05 A. M RICHFIELD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 28, 1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1□ M 2√ F 1920 HUNGARY 577-56-9363 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County work Examiner must be notified at Yes 2□No Director MARYLAND SILVER SPRING MONTGOMERY 286-1 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 5 20906 3701 INTERNATIONAL DRIVE, #645 UNITED STATES 238 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 2**X** No 1 Never Married 2 Married ō 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 'naturel' Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NATIONAL GEOGRAPHIC Elementary/Secondary (0-12) College (1-4or 5+) other then 3 12 **CLERK** SOCIETY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ROSENBERG MARGARET **GOLDMAN** ALEXANDER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NAOMI RICHFIELD-FRATZ, DAUGHTER 8112 LIONS CREST WAY, GAITHERSBURG, MARYLAND 20879 20a. Method of Disposition
1

Burial 2 □ Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Importent: If It eny injury or o once. 4 ☐ Donation 5 ☐ Other (Specify) 6/26/2005 KING DAVID MEM. GDN. FALLS CHURCH, VIRGINIA EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRACEANIAL HEMBRAHAGE 309-15 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

Box 68760 o ۵. Division of Vital Records, After Hospitel or Attending

after death Director:

24 hours a

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filled in by

Medical

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Registrar

31. Date filed (Month, Day, Year) 2005

FRANK J. MAID, MA

ing ly mar.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



SUN 213, GAZTHERIBURG MARYLAND 20877 16220 FREDEOZCK ROSA nach

29c. License number

123630

29d. Date signed (Month, Day, Year)

JUNE 24, 2005

			For Stete Registrar		State of N	Maryland / De		of He	ealth a	ind Me	ental H	ygiene Reg. 12.	0.0	5 2	2962
	Physicia	an	1. Decedent's Name (I		_" lan	Shrout			Sr.	-	2. Date of D	Day	Y	ear	Time of Death
	/Medic		4a. Facility Name (If no				4b. City, T				lul 9, 2		County of		1:47 am
	Examin	er	514 Broad			,	Cum			Dodui			legan		
	Funeral		5. Social Security Num	ber 6. Se	x 7.7	Age (In yrs. last birtho		1 Year	If Under 2	24 Hrs.	8. Date of E	Birth	9.		(State or Foreign
	Director		217-28-98 Usual Residence of De	01	QM 2□F	71 Yrs	i. Months	Days	Hours	Muli.	8. Date of E (Month, I Dec 2	9, 19	33	MD	
	land ow			0b. County		10c. City, Town o	r Location							10d. I	nside City Limits
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	or 28	Direc	10e. Street and Number				10f. Zip (10g. Citiz		t Country?	
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39	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show svent. Its Medical Examinating must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 [_	12. Was Deceder Armed Force: 1 Yes 2 [If Yes, Give Year or Dates]No	I3. Was Decede If Yes, speci		Mexican, Specify:	in? (Spec , Puerto R	tican, etc.)	İ	Black, Specify:	American II White, etc. Vhite	ndian,
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7	filed withi Hygiene. other than		17. Father's Name (Fit			Clerk			18 Mothe	r's Name	(First, Midd		X. Ra	ilroad	
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Maryland 21215-0036	2 = 2 = 2 = 2 = 2 = 2 = 2 = 2 = 2 = 2 =	ľ	19a. Informant's Nam Richard S		урө, Print) SON		ailing Address 52 Porte					nber, City or gdon	Town, Sta		^(e) 24210
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or othar tra		20a. Method of Dispos 1 Durial 2 X 4 Donation 5	Cremation 3 🗌	Removal from Sta	20b. Place of D cemetery, Scarpelli I	crematory or otl	her place,		Da	ate /11/200	1	cation - Cit	y or Town,	State MD
Baltir	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Fune			11	22. Name and Sca	Address rpelli	of Facility Funer	al Hon	ne, P.A	١.			IVID
			23a. Part1. Enter the	disease, or comp	lications that caus	ed the death. Do not	enter the mode	Virgir of dying	na Ave , such as e	enue; cardiac or	Cumbe respiratory	erland, arrest,	MD 21	Apr	oroximate
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rds	v requires been signi should be	ed b									15	Yes 2]No 3[] Probably	4 □Unknown
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of	> .ºº 0	٠ <u>۲</u>	1 Yes 2 □ No 27. Manner of Death)	1 ☐ Inpa			Other Bc. Injury	4 🗀 1401		e 5 X Re 8d. Describ			(Specify)	
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Division	r Attan ter deal irector	Certification:		6 Could not be determined	28e. Place of	Injury - At home, farmetc. (Specify)	, street, factory,				8f. Location City or T	(Street and	d Number o	or Rural Ro	ute Number,
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	1		of Maryland / Depa	artment of Health and National Artificate of Death	Mental Hygie		22261
		Decedent's Name (First, Middle, Last)			2. Date of Death	E 0 0 0	5: Time of Death
Physician /Medical	-	Mary Smith			June	24 2005	4:44 A
Examiner		a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Death	1
*		Prince George's Hos	pital	Cheverly		Prince	George's
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth Con 1933 W	nplace (State or Forei untry) ash., DC
	-	Usual Residence of Decedent	T. a. a.				
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Ba-f	3	DC		Washingt			
Dir	5	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	•
ns 23	0	3449 Minnesota Ave		20019 Was Decedent of Hispania Origin? (So	poity Von or No	United 14. Race - Amer	
Tun Fun	5	1 Never Married 2 Married 1 ☐ Ye	ecedent Ever in U.S. 13.1 Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
by Jan	2	3 ₩ Widowed 4 Divorced If Yes.	s 2 X No Give r Dates:	1 ☐ Yes 2 X No Specify:		Specify: B1	ack
glene "natural", or items 23s or 28s-1 si t, the Medical Examination positive Completed by Funeral Director	20	15. Decedent's Education	16a. Dece	dent's Usual Occupation	. 16	b. Kind of Business/l	ndustry
Med Med	- pic	(Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life.	kind of work done during most of work DO NOT use retired)	ring		
Gon th	5	12th		Housewife		Priv	ate
d oth	b	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
arka atlc	2	Charles Fie	elds		Frances	s Marlowe	
Department of Health and Mental Hygiene. Important: if Item 27 is marked other then. natural; or Items 23a or 28a-f show any righty or other traumatic event, the Medical Examination at ance. 2010. To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) Sonora Smith - Daught		ng Address (Street and Number or Rur 19 Minnesota Ave.,			
tem tem other	1	20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date 20	c. Location - City or T	own, State
at: If		1 ★ Burial 2 Cremation 3 Removal fro '4 Dogation 5 Other (Specify)	III States	natory or other place) National Cem. 7/5	/2005	Triangle	. VA
oortar injui	-	21. Signature of Furieral Service Licensee				neral Hom	•
Impo any ir		A Styrit Store	90 JTIL	4001 Benning Rd.	, N.E. Wa	sh., DC 2	0019
9.1		23a. Part1. Inter the disease, or complications the shock, in heart failure. List only one cause o	at caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
sician		Immediate Caust (Final disease or continion		ARRHYTHMIA			Onset and Death
edical	1	resulting in death)	to (or as a consequence of):	AKNALIAMIA			
miner	1	SEA	315				
e e	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):	_			
hysician and the burial-transit	5	that initiated events	TE KENAL F	FAILURE			
urial- urial-	Š	resulting in death) Last Due	to (or as a consequence of):				
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d by the attending phyletached for use as th	2	F FEMALE:				1	
igned by the attendir be detached for use by Physician/N	3	in the past 12 months?		Ectopic pregnancy		23d. Date of delive	ery Day Year
the shed	2	1 Yes 2 No 4 Pre 9 Unknown 9 Un		Other (specify)			,
detac detac		Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I	23e. Did tobac	cco use contribute to	the cause of death?
	2			,g g		2 □ No 3 □ Pro	
cate has been significant page 2 should	-						
2 0	-				24a. Was an autopsy performe	prior to co	opsy findings available empletion of cause of
certificate sector, pag		25. Was case referred to medical			1□ Yes 2 🕽		2 No
director, page	3	examiner?	7	Other	(Check only one)		
r this o			Inpatient 2 ER/Outpatien te of Injury 28b. Time of	1 3 DOA 4 Nursing Ho	me 5 ☐ Residenc 28d. Describe how	e 6 Other (Speci	fy)
tuner tion:	5	1 X Natural 5 ☐ Pending (M 2 ☐ Accident Investigation	te of Injury onth, Day Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No		,,	
To the Funeral Director: A completely filled in by the to	2	3 Suicide 6 Could not be	ice of Injury - At home, farm, str	eet, factory, office	28f. Location (Stree	et and Number or Rur	al Route Number,
al Director: After t ed in by the funera Certification:		4 Homicide determined bu	ilding, etc. (Specify)	,,	City or Town, 5	State)	
To the Funeral Director: After th completely filled in by the funeral Medical Certification:		29a. Certifier 1 Certifying Physician: To (Check only 2 Medical Exeminer: On the	the best of my knowledge, death	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caus	se(s) and manner as	stated.
the Fune ppletely fil ledical		and in	anner stated.	vestigation, in my opinion, death occurr	eu at the time, date	and place, and due t	o the cause(s)
Com Com		29b. Signature and title of certifier		29c. License number	29d.	. Date signed (Month,	
		1 / lestal	repe-	3 D 52865		6-27.	- 05
3)		30. Name and address of person who completed of K. MICHAEL FIGAK	use of death (Item 23a) (Type,	Print) SPITAL DR	CHEVER	/ A17	2010=
0	1	31. Date filed (Month, Day, Year)	. Registrar's Signature	WITHE OR	CHEVEX	1 NID C	20/80
State Registrar		JUN 2 9 2005	La de La	R,			
17 Pov 1/2001		3014 2 3 2003	we is again				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		1 - For State Registrar	state of Marylar		tificate of L		, ,	giene Reg. No. 🔿 🙃		
Physic		Decedent's Name (First, Middle, Last) ALICE THEL	MA STRICK	ER		-	2. Date of Dea Month JUNE 2	ath Day	05	32in20965 3:50 PMM
/Med Exam		4a. Facility Name (If not institution, give stre			4b. City, Town, or			4c. County	of Death	· · · · · · · · · · · · · · · · · · ·
		Reeder's Memorial H		lone high days	Boonsbo	oro If Under 24 Hrs.	O Data of Bird	h	hingt	
Funera Directo		5. Social Security Number 181-14-0607 Usual Residence of Decedent	7. Age (In yrs. 94	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 5,	1910	Peni	place (State or Foreign htry) nsylvania
anyland show	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	Od. tnside City Limits
he Mi	ecto	Maryland Frederic	k	Myersv	ille 10f. Zip Code	-		10- 01	Mb - 1 0	1 ☐ Yes 2¶ No
3a or	i Dir	10509 Church Hill Ro	ad		21773			10g. Citizen of t	what Cour	try !
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatlih and Mental Hygiene. Important: if item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at any once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specifi	ce - Americ ck, White, v: Wh	
72 hou	ted	15. Decedent's Educat (Specify only highest grade c	ion	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	ition	ring	16b. Kind of B	usin <i>e</i> ss/Inc	dustry
vithin ne. hen."	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mana)	9	Reta	<i>t</i> 1	
Hygie thert		12 17. Father's Name (First, Middle, Last)		Halla		18. Mother's Nam	e (First, Middle,			
id be lental ked o	To Be	Logan Straw					Ross		,	
and M and M s mar	-	19a. Informant's Name/Relationship (Type	Print)	19b. Mailin	g Address (Street a	nd Number or Rui	al Route Numbe	r, City or Town,	State, Zip	Code)
1 and 2 Health a em 27 is		Bruce Whistler - so			Church H					
Pages 1 nent of H ant: if ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place g Cremato		Date 5-2005	20c. Location - Smithsb	-	wn, State Maryland
permit. Departiment any inj		21. Signature of Funeral Service Ligenshe	arte		. Name and Address			Main S rsville		
Physician		23a. Part I. Enter the disease of complicate shock, the rt failure. List only one Immediate Cause (Final disease or condition		th. Do not ente						Approximate Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to (or as a consec						- (24*
rificate be executed g physicien end as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as a consec							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)			23d. Da Mo	te of delive	ry Day Year
es that igned b	by	Part II. Other significant conditions contril	- 1	sulting in the ur	nderlying cause give	n in Part I.				e cause of death?
requii	eted	ens-slage o	rganie l	rain	synd	rine	1 🗆 Y		3 Prob	ably 4 Unknown
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iclan certific	Be	25. Was case referred to medical examiner?	pital:		Othe	26. Place of Deat				
ling Phys	ion: To	27. Manner of Death Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at Nursing Ho	nme 5 🔲 Resid 28d. Describe h			9
Atten or deat octor: by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre		92 2 140	28f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	l Route Number,
To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	ledicai C	29a. Certifier Check only one) Certifying Physic 2 Medical Examiner	ian: To the best of my kno : On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the ored at the time, or	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
To th within To th	Me	29b. Signature and title of certifier			29c. License	number	4	29d. Date signe	d (Month, i	Day, Year)
		Republit			D32	518	23	6/24/0	5	
2.		30. Name and address of person who comp					0175	C / 201	420	2222
-	tate	DR. ROBERT GUEDENET. 31. Date filed (Month, Day, Year)			, KEEDYSVI	ILLE, MD.	21/5	6 / 301	-432-	
Regis	tate trar	JUN 2 7	32. Registrar's Signa 2005	o B	Assert !					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE Month 8:55P 23, HELEN LOUISE SMITH 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2**X**□ F 78 216-22-7534 Yrs Director 25,1927 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Frederick Frederick Directo Maryland 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21701 703 Maxwell Avenue 23a filed within 72 hours after death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "naturel", or Items 1 Never Married 2 Married 1 Yes 2N No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If Item 27 is marked other the any injury or other treumatic event, Item 2006. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sadie B. Wine Harry Copp ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Rosewood Crt., Unit 311, Woodsboro, MD 21793 Patty Weddle / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Pleasant Hill Cemetery 6/27/2005 Frederick, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signary of Funeral Service License 22. Name and Address of Facility 2. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 e, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part 1 Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Pnysician disease or condition resulting in death) Hous /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at id be detached fo 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ▲ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? s after death. uneral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel within 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintenance and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 29c. License number D43091 6-24-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saced Zaidi' M 80(Tou House Ave MO 301 31. Date filed (Month, Day, Year) 2 UN 2 32. Registrat's Signature State

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Registrar

Stade .

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death S. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 Month **Physician** Lawrence Alan Siegel June 17, 5:50 A.MM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritchie Hospice Baltimore None 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 10, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Director 1945 577-56-8280 Wash. D. C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Directo 1 Tyes 2 No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 7701 Periwinkle Way 21144 U. S. A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2□No Army If Yes, Give Year or Dates: Reserve Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o filed within 72 hours after d I Hygiene. other than "natural", or item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White þ Specify: 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental 7 ts marked o Samuel Siegel Celia Pekover 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 to any injury or other tra 7701 Periwinkle Way, Severn, Maryland 21144 Darlene M. Hill - Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State 6/20/2005 National Crematory Falls Church, Virginia ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Edward Agelac Funeral Direction, Inc. Donald -1091 Rockville Pike, Kockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ProstATE CANCER **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 2 🗌 No 1 🗌 Yes 2 🗹 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 🗷 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ran, ill 6-17-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL #907 BALTIMORE, LID 21202 8 , us X. STRAIN til FRANCIS 32. egistrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Marylar			of Health a	ınd Me		jiene	005	22968
	Physici /Medio		1. Decedent's Name (First, Middle, La: Joseph David S	stockstill				2	Date of Dea Month June	25,	2005	3. Time of Death
	Examir		4a. Facility Name (If not institution, give				vn, or Location o	f Death		4c. C	ounty of Deat	h
			Laurel Regional H				urel	24110				eorge's
	Funeral Director		2.2 00 003.	ex 7. Age (In yrs.	75 Yrs.	If Under 1 Y Months Da	ear If Under 2 ays Hours	Min. A	Date of Birth (Month, Day Aug. 10	1929	9. Birti Co Was	nplace (State or Foreign unity) hington, D.C
	Maryland -1 show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 X No
	th with the 23e or 28e let be not	Funeral Director	10e. Street and Number 5106 Caverly Plac	e		10f. Zip Coo	de 20705	5			n of What Co	-
036	d within 72 hours after death with the Maryland jene. In than "natural", or Items 23e or 28e-1 show It's Mudical Examinetr und be mulified at	Ď	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (of Hispanic Orig Cuban, Mexican, No Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		. Race - Ame Black, White pecify:	
21215-0036	within 72 ho ene. than "natur re Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use re	one during most stired)				of Business/	industry
land 21	ld be filed w ental Hygier ked other th ic event, the	To Be Cor	17. Father's Name (First, Middle, Last, Clark P. Stocks	still	ETect	rical	Journeyn 18. Mothe Inna	r's Name (/	First, Middle, ila K		И, #70 итате)	
, Maryland	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 2006.		19a. Informant's Name/Relationship (Julia M. Yocum -				reet and Number in Creel					
Baltimore,	Pages 1 announce of the Int: If Item		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specification)	Removal from State	cemetery, cre	osition (Name of matory or other coln Cei	netery (Dat 6/29/3			tion - City or	rown, State Maryland
Balti	permit. Departr Imports any Inje		21. Signature of Funday Service Licent	Hier hors	7 Dx 44	2. Name and Ad Onald V 400 Pow	ddress of Facility Borgwa	ardt 1 1 Road	Funera d Belts	l Hom	e, PA e. Mar	yland20705
	Pnysician		23a. Part1. Enter ne disease, or com shock, or Jeart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line.	th. Do not en	ter the mode of	dying, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
0,	/Medical Examiner sicien and pnuial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	Carcino quence of): tructiv		onary Di	isease	9			
68760,	rtificate be ex ng physicien as the buria	Medical	IF FEMALE:	_ d								per annual services
.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a 9 Unknown	al death 3	□Ectopic pregna □ Other (specify				230	d. Date of deli Month	very Day Year
ords, P	The law requires that tte has been signed b age 2 should be deta	by	Part II. Other significant conditions of Seizure Disorder	contributing to death but not re	sulting in the u	inderlying cause	e given in Part I.					the cause of death?
of Vital Records,		Completed						_	24a. Was a autop: perfor 1 Yes	ned?	24b. Were au prior to d death? 1 🗌 Yes	topsy findings available ompletion of cause of
Vita Vita	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner?	Hospital:					Check on or			
	ding After fune		1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c.	Other: 4 Nur Injury at Work? 1 Yes 2 1	280	5 Resid			ify)
Division	i Diffe	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - Ath building, etc. (Speci	iome, farm, st ify)	reet, factory, off	fice	281	f. Location (S City or Tow	treet and f n, State)	Number or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	one)	nysicien: To the best of my kn niner: On the basis of examinated and manner stated.	owledge, deat ation and/or in	h occurred at the	ne time, date and my opinion, deat	d place, and h occurred	d due to the c at the time, d	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause(s)
)	17 company	W	29b. Signature and title of certifie	mun			oense number 013687		2		Signed (Month	•
	10		30. Name and address of person who Joselito Magday,	M.D. 11701 Ro	oby Ave	nue Bel	ltsville	, Mar	yland	2070	5	
	Sta Registi	-	31. Date filed (Month, Day, Year) JUN 28 200	2. Registrar's Sign	ature Cos	le						

			For	State of Maryla	ind / Dep	artment o	of Health and	Mental Hy	/giene		
			1 - State Registrar		Ce	rtificate	of Death	1.2	Reg. No.	2005	22000
	Physici	an	 Decedent's Name (First, Middle, La. Joseph 	•	zano			Month	Day		3-4 India of Death
	/Medic					11 00 T		June 2		005	9:18 PM ^M
	Examin	er	4a. Facility Name (If not institution, give				wn, or Location of Dea	th		County of Dear	
	Euroval		Holy Cross Hospit 5. Social Security Number 6. S		s. last birthday	If Under 1 Y	r Spring	S. R Date of Ri		ntgome	J
	Funeral Director			Š M 2□F 82	Yrs.		ays Hours Min		ay, Year) , 192	New	thplace (State or Foreign buntry) York
	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show than "hedless Exercities freast be rediffed at		10a. State 10b. County	10c.	City, Town or L	ocation					10d. tnside City Limits
	Marist	ţo	Maryland Montgome	ry Ro	ckvill	e					1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Co	ode		10g. Citi	zen of What Co	ountry?
	th wi	ai	14319 Briarwood I	'errace		2085	3		Unit	ed Stat	tes
	ema erra	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No	0-	14. Race - Ame Black, Whit	
36	or It		1 ☐ Never Married 2X Married	Armed Forces? 1 ⊠Yes 2 □ No. If Yes, Give 1943 Year or Dates: 192	3_	1 ☐ Yes 2 💢				Specify:	в, віс.
Ö	ural	d b	3 Widowed 4 Divorced	Year or Dates: 192						WI	nite
7	"nat	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual O	occupation fone during most of wo retired)	orking	16b. Ki	nd of Business/	Industry
7	withii ene. than	щ	Etementary/Secondary (0-12)	College (1-4or 5+)		nomist	60/60)		II C	C	
2	filed with Hygiene. other than	ŭ	17. Father's Name (First, Middle, Last)		ECO	IOMITS	18. Mother's Na	me (First, Middle		Govern	ment
an	d be entat kad o c eve	To Be	Guiseppe Salz				Mary	Siefe		ournamo,	
Maryland 21215-0036	shoutd tind Ment	F	19a. Informant's Name/Relationship		19b. Maili	no Address (Si	treet and Number or Fi			r Town State	Zin Code)
	~ ~ ~ ~		Jane Salzano / wi				wood Terra				
Baltimore,	s 1 and 2 f Health itam 27 othar tra		20a. Method of Disposition	206				Date		cation - City or	
Ë	Pages ment of h ant: if its		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specification)	Removal from State A	Place of Disponder, creating to	n Natio	onal July	21,	Ar1:	ington,	Virginia
픑	permit. Page Department Important: if any injury a		21. Signature of Fineral Service Licer		_Ceměte	2. Name and A	ddress of Facility Th	ibadeau	Mort	uarv Se	ervice, P.A.
Ö	Departing Department of the sany in sa		follow	M00956			Avenue, #			-	
			23a. Part . Enter the disease, or com shock, or heart failure. List only	otications that caused the de	eath. Do not en	ter the mode of	f dying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
L.	Pnysician		tmmediate Cause (Final disease or condition		D.21						Onset and Death
	/Medical		resulting in death)	a. Respirator		re					Immediate
d	Examiner		Conventially list and division	b Pulmonary 1	Fibrosi	5					Years
	D ==	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons							
	nd nd trans	Examiner	that initiated events	c							
760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
876	ate b hysic the b	dicai		d							
Ø X	death certifical e attending phy of for use as th	Physician/Med	IF FEMALE:	00 11							
Вох	ath c attenct for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of prec	etal death 3	Ectopic pregn			2	23d. Date of del	ivery Day Year
0	0 00 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	f death 5	Other (specif	ý)			MOTO	Day Tear
٥.	The law requires that the de ite has been signed by the a page 2 should be detached i	Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	ndarkina caus	a awan in Part I	23a Did	tobacco u	sa contributa to	the cause of death?
Records,	ires tha signed d be det	d by	Diabetes	ominating to doubt but not t	oodking in the c	riderlying caus	e giveirii i aiti.				obably 4 Unknown
0.0	w require been sig should b	etec	Diabetes		<u> </u>						
3ec	e law has l	Completed						24a. Was	psy	prior to o	topsy findings available completion of cause of
_								1 Tes	ormed? 2 X No	death?	2□ No
Vital	Attending Physician: The Is r death. actor: After this certificate ha: by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only			
ot	Phys r this ral di	10	1 ☐ Yes 2 💢 No 27. Manner of Death	1X Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time o		Other: 4 Nursing I	Home 5 Resi			cify)
no	ding Ph h. After thi funeral	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ No	Zou. Describe	now intury	y occurred	
Division of	i or Attend after death Diractor:	fica	3 Suicide 6 Could not be		home farm str			28f Location (Street and	d Number or Qu	ral Route Number,
<u>S</u>	_ 0	Certification;	4 Homicide determined	building, etc. (Spe	cify)	cot, lactory, or	1100	City or To	wn, State))	rai noute ivalliber,
	To the Hospital o within 24 hours aft To tha Funaral Di completely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, deat	h occurred at the	he time, date and plac	e, and due to the	cause(s)	and manner as	stated.
	n 24 h	edical	(Check only 2 Medical Exam one)	niner: On the basis of exami and manner stated.	nation and/or in	vestigation, in	my opinion, death occ	urred at the time,	date and	place, and due	to the cause(s)
	To the within To the Comp.	Me	29b. Signature and title of certifier				cense number			signed (Month	
	111		be l'ar llut	5 MD		\mathcal{Y}	4435		Jun	12 ZY	21205
	lo		30. Name and address of per n who	completed cause of death (It	ет 23а) (Туре,	Print)	1		,	- 7	-000
			Ira Var I Weff	ng, MO	1030	160	orgia Kins	enve >	iller	Sprine	2005 20902
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 2	32 Registrar's Sig	St. Sp.	will					

	_	For State Registrar	State of Maryland		artment of F		Reg	10 On	5 22970
Physici /Medic	cal	Decedent's Name (First, Middle, Last, Sonia Aa. Facility Name (If not institution, give)	C. Taylor		4b. City. Town, o	r Location of Dea	2. Date of Death Month June	Day	Year 3. Time of Death 1005 9:45 A
Examin Funeral Director	ier	Prince George's 5. Social Security Number 6. Security Number 15.	Community Hos			Cheverly	s. 8. Date of Birth	Pri	nce George's 9. Birthplace (State or Foreig Country) Illinois
ne Maryland 8a-f show	Director		George 's	, Town or Lo	Uppe	r Marlbo			10d. Inside City Limit
be filed within 72 hours after death with the Maryland tital Hygiene. od other than "neturel", or Items 23a or 28a-f show event, I'm Medicul Examiner most be rediffed at	by Funeral	10e. Street and Number 9504 Tiberia 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Nas Decedent of H f Yes, specify Cubi	20772 dispanic Origin? (. an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race	ted States - American Indian, , White, etc. Black
filed within 72 hc Hygiane. Ither than "netur ont, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Sec	during most of wo	orking	6b. Kind of Bus	ernment
should be filed ind Mental Hygir marked other umatic event, I	To Be	17. Father's Name (First, Middle, Last) Fred Somers 19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street		ame (First, Middle, Ma Vio Bural Route Number,	Let Eng	land
es 1 and 2 of Health a fitem 27 is r other tre		Diane Calvin - □ 20a. Method of Disposition 1 Burial 2 Cremation 3 □F 1 Denation 5 □ Other (Specify)	20b. Pl.	950 ace of Dispo	4 Tiberi	as Dr.,	Upper Marl	Lboro, I	MD 20772 City or Town, State
permit. Page Department Importent: Il any injury o	L	21. Signature of Funeral Service Licens 23a. Pagn. Enter the disease, or compi	Stewart 1	22		ss of Facility enning R	2/2005 Stewart I d., N.E. V	Funeral Vash.,	
Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ne cause on each line.	NTRA (MORHAGE		Interval Between Onset and Death DAYS
ficate be executed g physician and is the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	rence of):		7			
that the death certificate ed by the attending physical detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mont	of delivery h Day Year
v requires been sign should be	by	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	1 ☐ Yes	2 □ No 3	oute to the cause of death? B Probably 4 Unknow
The ate his page	Be Completed	25. Was case referred to medical examiner?					ath Check on one	ed? de X No 1[ere autopsy findings available or to completion of cause of ath? Yes 2 No
ling Phys I. After this uneral dir	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 X Inpatient 2 E 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	y at k? Yes 2 □ No	Home 5 Resident 28d. Describe how		
To the Hospitel or Attend within 24 hours after death To the Funerel Director: . completely filled in by the f	ai Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify sician: To the best of my know	·)		me date and plac	City or Town,	State)	r or Rural Route Number,
To the Hos within 24 hr To the Fun completely	Medical	(Check only one) 2 Medical Exami 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	ion and/or in	vestigation, in my o	ppinion, death occ	curred at the time, dat	e and place, ar	(Month, Day, Year) MD 20785
0 (6)		30. Name and address of person who co		23a) (Туре, -/32	Print) LANDOVEA		0		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Eunice Thompson 24, June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Pay, 5/26/23 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Year) 1 M 2 TXF Yrs. Director 579-26-7383 Gantt, S.C Usual Residence of Deceden 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28e-f show treumatic event, the Wadical Examinar must be notified at Director 1X Yes 2 □ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20010 1032 Kenyon St., N.W. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, African-1 end 2 should be filed within 72 hours after of teath and Mental Hygiene. 9m 27 Is marked other than "neturel", or Itel 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistical Clerk - GAO U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Thompson Sadie Rosemond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Sandra O. Edwards/Niece # 61 Seaton Pl., N.W., Washington, D.C. 20001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o once. ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cem. 7/2/05 * 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. 22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 21. Signature of Funeral Service Licenses any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE 957 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.O. the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate Division of Vital 1 🗌 Yes 2 No 1 Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Stother (Specify) HOS 16 P 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 ş 29b. Signature and I 29d. Date signed (Month, Day, Year) 29c. License number D35635 June 25, 2005 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill , Rockville, Md. 20855 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	пукано / Бера Сел	tificate of				
			Decedent's Name (First, Middle, Last,)		incate or i	Dealit		ith 2005	23Clime of Death
	Physici		Mary Emma	Twenty				June 2	23 Day 2005 Y	(9:40 PM
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of I	
			Lorian Nursing Ho	me		Mt.	Airy		Car	roll
	Funeral		5. Social Security Number 6. Security Number 1.0	TH OFF	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	91	Yrs.			Aug. 18	, 1913	Maryland
	tand tand		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary Fied	ţō	Maryland Howard		Woodbine					1 ☐ Yes 2 🛣 No
	r 28e	Director	10e. Street and Number		oodb2me	10f. Zip Code			10g. Citizen of Wha	it Country?
	23a c	ai	16229 Frederick Ro	ad		21	.797		United St	tates
	eep .	Funeral		12. Was Decedent 8 Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto		14. Race -	American Indian, White, etc.
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☒N If Yes, Give	0	I∐Yes 2√x No		,	Specify:	
21215-0036	be filed within 72 hours after deeth with the Maryland tal Hyglene. Id other than "naturel", or Items 23a or 28e-f show of other than "naturel", or Items 12a or 28e-f show event. The Medical Examinat must be notified at	q pe	3 X Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	162 Door	lent's Usual Occup	ation			White
15	n "na	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of NOT use retired	during most of work	ring	16b. Kind of Busin	ess/maustry
212	e filed within it Hyglene. other then "	mo	Elementary/Secondary (0-12)	College (1-4or 5-		pervisor	•		Public S	Schools
b	be filed ital Hygli id other event, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>Ja</u>	should by		Arthur Monroe Burd	ette Sr.			Effie L	. King		
Maryland	2 8 8 2		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	g Address (Street	and Number or Rur	al Route Number	r, City or Town, Sta	te, Zip Code)
	ss 1 and 2 should of Health and Men item 27 Is marke cother treumatic		Mary Jane Fleming/	Daughter	16229 20b. Place of Dispo		k Road, V		, Marylan	
JO.	iges if ite or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		cemetery, gren	natory`or other plac	6/26/	2005	20c. Location - City	y or Town, State
Baltimore,	it. Pa intmer intent injury		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 		Damaseus		t Cemeter	y I	Damascus,	Maryland
Ba	permit. Pages. Department of It Importent: If Ite any injury or of once.		Foll OC	Unn	01	Name and Address in L. Mo. 401 Ridge	lesworth	P. A. Fu	uneral Ho Marylan	me d 20872
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DE	MENTIL	}				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
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	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	out to per use						
Ć.	execu n and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit			d						
_	tifica ng ph as th	Physician/Medical	Te cerus							
Вох	eath cer attendir for use	an/N	250. Was decedent prognant	3c. If yes, outcome of		Ectopic pregnancy	,		23d. Date of	
	e death the atte	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at t		Other (specify)			Month	Day Year
D. O.	that the de ned by the a detached f	Phy	Part II. Other significant conditions col	ntributing to doub bu	t not reculting in the	d=-1-i	an in Oard I	220 Did to	hones was contained	to to the course of death?
Vital Records,	slgne d be c	l by	ASCV		t not resulting at the di	deriying cause givi	en in raiti.			te to the cause of death? ☐ Probably 4 ☐ Unknown
Ö	w require been slo should t	etec						-		
Rec	The lav ate has page 2:	Completed						24a. Was a autops perfor	sy prior	e autopsy findings available to completion of cause of h?
(a)		e Co	25. Was case referred to medical				00 81	1 Yes	2 NO 1	
5	Physicien: r this certific ral director,	0 B	examiner?	lospital: 1 ☐ Innatier	nt 2 ER/Outpatien	Othe	26. Place of Deat		ence 6 Other (Speciful
o o	g Phy er thi	n; T	27. Manner of Death	28a. Date of Injury (Month, Day		28c. Injury Work			ow injury occurred	Spacily)
0	Attending Property of the funeral type the funeral type f	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		Yes 2□No			
Division	el or Attendii s after death, el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (St City or Town		r Rural Route Number,
	urs af rel D									/
	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier 1 Certifying Physical (Check only 2 Medical Examination)	sician: To the best o ner: On the basis of and manner stat	f my knowledge, death examination and/or inv ed.	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the within Fo the comple	Me	29b. Signature and title of certifie			29c. License	e number	2	9d. Date signed (M	fonth, Day, Year)
				t1 ()	1	D.	31912	and the same of th	6/25	105
	0		30. Name and address of person who co			Print)			7.00	- 1
	2		Julio MEMO	-		OPOSSUL	m70wn	Plu4	MED	ENICH MD
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	Soul!				31100

			1 - State	State of M	larylan			ent of He a <i>te of D</i>		Mental Hy	/giene	9	
			Registrar 1. Decedent's Name (First, Middle	. Last)		Cei	unce	ile Oi L	eaui	2. Date of D	Reg. No	2005	22073
ı	Physici		GRACE	,	LMA		ТУ	RON		Month JUNE	Day 14	y Year 2005	7:25P M
	/Medio Examir		4a. Facility Name (If not institution	give street and number,)		4b. Ci	ty, Town, or I	Location of Dea			County of Dea	
			FREDERICK M	MORIAL HO	SPIT	AL		REDER			F	REDER	CK
ľ	Funeral Director		5. Social Security Number 372–07–4090	6. Sex 7. A	ge (In yrs. I	ast birthday) Yrs.	If Und Month	der 1 Year Is Days	Hours Min		irth ay, 190	9. Bir 9 Mich	nthplace (State or Foreign ountry) 11gan
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary	tor	Maryland Frede	cick	Fre	ederic	k						1 TYes 2 No
	th the	Director	10e. Street and Number				10f. 2	Zip Code			10g. Cit	izen of What C	ountry?
	ath wi	rai	14 East South					2170				USA	
Maryland 21215-0036	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show idical Examirme Innat be redified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces of 1 Yes 2 If Yes, Give Year or Dates:	? No			37	panic Origin? (, Mexican, Pue Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whi Specify: Wh	te, etc.
2-0	72 hc	etec	15. Decedent (Specify only highes	s Education grade completed)		16a. Deced	dent's U	sual Occupat	ion Iring most of wo	nrking	16b. K	ind of Business	/Industry
121	d within 72 ho piene. r than "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		igne igne		ŭ	3	0	wn Busi	ness
d 2	Hyg the		17. Father's Name (First, Middle, I	ast)		Des	-6110		18. Mother's Na	me (First, Middle			iness .
/an	a da b	To Be	Almon	Ivan	Pe	lter			Grace			beth	Collins
lary	and and sum		19a. Informant's Name/Relationsh				ng Addre	ss (Street ar		ural Route Numb			
	s 1 and 2 f Health item 27		Alexandra K. Ty	ron-Hopko/Da					Street,	Frederi			
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		e Ce	lace of Dispo emetery, cren	natory o	r other place	1	Date	20c. Lo	ocation - City or	Town, State
語			* 4 □ Donation 5 □ Other (Sp 21. Signature of Puneral Service I		Fre	ederic	k Cr	emator	y 06/	22/05	Fre	derick.	MD
Ba	permit. Departu Imports any nju		& CUMO O							auffer Pike, Fr			
			23a. Parti. Enter the disease, or slight, or heart failure. List	complications that cause	ed the death	n. Do not ente	er the m	ode of dying,	such as cardia	c or respiratory a		ick, in	Approximate Interval Between
뾜	Physician		Immediate Cause (Final disease or condition	Conic	t-Sta	EVE H	101	RT	FAIR	DRE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ience of):							104EARS
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	d consequ			ر الما			-		107113
	cuted nd ransit	Examiner	that initiated events	c.									
, 00,	oe exe clan au urial-t		resulting in death) Last	Due to (or as	s a consequ	ience of):							
68760,	tificate be executed og physician and as the burial-transit	edicai		d									
	= O 6	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy						23d. Date of de	livon
. Box	death certi e attending id for use a	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic Other (pregnancy specify)				Month	Day Year
P.0	Ihat the de led by the a detached i	Physicia	9 □ Unknown	9□ Unknown							-1		
	36	by	Part II. Other significant condition	as contributing to death t	but not resu	Ilting in the un	nderlying	cause giver	in Part I.			4	the cause of death?
Ö	w require been signal	eted	CORDWARY DEGENER	ATTOR	1814	0555	6			+			robably 4 Unknown
Vital Records,	The law ate has page 2 s	ompieted	70-42000	7	TO 11.	4/1				24a. Was auto			utopsy findings available completion of cause of
ta		e C	25. Was case referred to medical						G Place of Do	1 ☐ Yes ath Check onl	2 No		2 □ No
Ξ		To B	examiner? 1 ☐ Yes 💇 No	Hospital:	ent 2 🗆 E	ER/Outpatien:	t 3[][dome 5□Resi		6 ∏Other (Spe	cify)
n of	ng Ph fter thi		27. Manner of Death Natural 5 ☐ Pending	28a. D te of Inju (Month, Da	ury ay Year)	28b. Time of Injury		28c. Injury a Work?	it	28d. Describe			
sio	tendi death, tor: A the fu	cati	2 Accident investig	ation of the			М	1 □ Ye	s 2 No				
Division	after of Direct Direct of in by	Certification	4 Homicide determi	ned 289. Place of In	iury - At hor tc. (Specify	me, farm, stre	eet, facto	ory, office		28f. Location (City or To			ural Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	edical C	29a. Certifier (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	ot examinati	wledge, death ion and/or inv	occurre estigation	d at the time on, in my opir	, date and place nion, death occi	a, and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	To the comp	Ň	29b. Signature and title of certifier				2	9c. License	CO7			e signed (Monti	
,			Mary t. A					404	GUT-	٠	Jur	ne 14, 2	2005
	2		30. Name and address of person w)r E	odowi -1	MD 2174	12		
	Sta	te	31. Date filed (Month, Day, Year)	22 Deficts	rar's Signat	ure			edelick	, FIJ 21/(JZ		
	Registr		JUN 2	3 2005	Shore .	K A	Line	¥ 1					

_			1 - For State Registrar		Marylan	•	artment of H			Reg. No.2	005	22071
	Physici /Medio		Decedent's Name (First, Middle, LOUIS WESLEY VO	,					2. Date of D Month	Day	Year	21:35 P.M
9	Examin		4a. Facility Name (If not institution,	give street and numbe			4b. City, Town, or	Location of Death			unty of Death	12133 20
	Funeral		5. Social Security Number 6	. Sex 7. A	Age (In yrs.	last birthday)	BERLIN If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	RCESTE 9. Birthi	
	Director		217-09-7673	X M 2 □ F	83	Yrs.	Months Days	Hours Min.	7/10/1	921	MARY	place (State or Foreign ntry) LAND
	show		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	e Man Se-1 sh Iillied	Director	DELAWARE SUSSE	X	SEL	BYVILL	3					1 ☐ Yes 2X No
	after death with the Man or Items 23s or 28e-f sh out at must be notified		10e. Street and Number 44G BLUE BILL D	RTVE			10f. Zip Code 19975				of What Cou	ntry?
	death	Funeral	11. Marital Status	12 Was Decoder	nt Ever in U.	.S. 13.	Was Decedent of H		pecify Yes or N	U.S.	Race - Ameri	
36	within 72 hours after death with the Maryland ene. hen "naturel", or Items 23s or 28e-f show he jigst Eta ciliet must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces Armed Forces 1 2 Yes 2 [If Yes, Give Year or Dates	יי ⊒No 30–/₁י		Tes, specily Cuba		nican, etc.)		Black, White,	etc. HITE
5-0036	72 hou nature		15. Decedent's (Specify only highest	Education	· J 7 -	16a. Deced	ient's Usual Occup	ation	vin a	16b. Kind	of Business/In	dustry
5-121	within 7	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)	life. I	kind of work done of DO NOT use retired EQUIPME	1)		СТББ	I MEG	
5/2/	filed Hygir ther	a	8 17. Father's Name (First, Middle, La	ıst)			DQUITIE	18. Mother's Nam		ــــــــــــــــــــــــــــــــــــــ	L MFG.	
- 19/2 - 20 Vland		To B	LOUIS WESLEY VO	GEL SR.				GLADYS				
Mar Na	2 sh and Is m		19a. Informant's Name/Relationship REGINA E. VOGEL				ig Address (Street a					
- 10	Heal Heal tem 2		20a. Method of Disposition	-		lace of Dispo	sition (Name of natory or other place		Date Tate		E • 199 ion - City or To	
SB 7- C Baltimore	Page ment c ant: If		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		10		VET. MEM	l l	1/05	MILLS	BORO, I	Œ.
PCB OeD ■ Ball	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lie	. Wat	en	WA	Name and Address	ERAL HOME		SBORO,		3
2			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplications that caus my one cause on each	ed the deat	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory	arrest,	2	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or a	HETIC as a consee	uence of):	nemia 1	with s	sepsis		2	
60	Examiner	_	Sequentially list conditions,	b. Ten	e to	ulure	/					
673	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence of):						
- 7	s be executed sician and burial-transit		that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):						
c/ ~	cate be physici the bu	dlcal		d								
OX 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna		-			23d	Date of delive	erv
17.	0 00	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ⊡Live birth 4 □ Pregnant 9 □ Unknown	at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
Ck G	es that igned b	by Pł	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?
Second Record	w requir been si should	eted								Yes 2□N		
	The law ate has I page 2 s	ompleted		<u> </u>						ormed?	prior to con death?	psy findings available mpletion of cause of
X ital		Be Co	25. Was case referred to medical examiner?		/			26. Place of Deat	1 ☐ Yes	2 No one)	1 🗆 Yes	2 □ No
7.5 of V	Phys this al di	၉	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatien		4 Mursing no				y)
		atlon:	1 atural 5 Pending 2 Accident investiga	28a. Date of Ir (Month, L	Day Year)	28b. Time of Injury	Work	/at ⟨? Yes 2 □ No	28d. Describe	now injury oc	curred	
LOU Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certifica	3 Suicide 6 Could no 4 Homicide determin	t be ad 28e. Place of I building,	Injury - At ho etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office		28f. Location City or To	(Street and Nown, State)	umber or Rura	l Route Number,
	spitel o		29a. Certifier 1 Certifying	Physician: To the bes	st of my kno	wledge, death	occurred at the tirr	ne date and place	and due to the	cause(s) and	manner as si	atad
*	To the Hospitel within 24 hours a To the Funerel Completely filled	ledical	one) Medical E	aminer: On the basis and manner	of examina	tion and/or in	estigation, in my or	pinion, death occur	red at the time	date and pla	ice, and due to	the cause(s)
	To t To t	Z	29b. Signature and title of certifier	1 . /	0 A		29c. License	36/2		29d. Date s	gned (Month,	Day, Year)
			30. Name and address of person wi	completed cause of	f death (Item	23a) (Type		10010		4/	70.	
CH	10+1		ANDREA BAIER, M.	D., 9733 H			•	IN, MD, 2	21811			
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9	2005 32. Figis	strar's Signa	ture	porte					

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siciar			an Lev									JULY	Da	20	Year	9:42P.
edica miner	4. 5				street and no	umber)			4b. City	Town, or	Location of Deat		40	County	of Death	9.44E.
me			TRICK	_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				ERIC			1	EDEF		
ıl r		Security		6. Se	x X M 2□ F	7. Age	(In yrs.	last birthday 2 Yrs.) If Under Months	1 Year Days	If Under 24 Hrs Hours Min.		irth ay, Year) 197	3	Cou	place (State or F ntry) qinia
	Usual R		of Decedent				10- 01	v. Town or L								
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			trick	Stro	a+						21703					•
Finorial	11. Mar	al Status	CT TON	Date	12. Was Dec		ver in U.	.S. 13.	Was Deced		spanic Drigin? (S n, Mexican, Puer	pecify Yes or N		14. Race		can Indian,
È	3 □		rried 2 N		Armed F 1 📋 Yes If Yes, G Year or I	2 XNo live			1 Tes		n, Mexican, Puer Specify:	to Rican, etc.)			k, White,	
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Ш	1 🔀	Burial 2	2 ☐ Cremati		Removal from	State	C	emetery, cre	matory or o	ther place						
	-		5 🗌 Other				NOS	se Hil		-	•					Maryland
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	23a Pa	t1. Enter	the disease	or comp	ications that	caused to	he death				g, such as cardia)WII I	aar y 1	Approximate
	sh	ck, or he	art failure.	List only o	ne cause on	each line).					or respiratory i	211031,			Interval Betwe Onset and De
n al	disease	or conditi	ion	-	a		_	a1coho	or int	OXIC	ation					
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Į d	Sequen	ially list cading to i	onditions, mmediate		Due to	(or as a	consequ	uence of):								
15.	Cause (Disease o	r injury	1												
Fxaminer	resulting	in death)		1	Due to	(or as a	consequ	uence of):							_	
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Physiclan/Medic	JF FEM. 23b. W		nt pregnant	. 2	3c. If yes, ou	utcome of			Tetonion					23d. Date	e of delive	
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hve	9[Unknow	n		9□ Unkr	nown										
by P	Part II. C	ther sign	ificant cond	ditions co	ntributing to d	death but	not resi	ulting in the	underlying ca	luse give	n in Part I.	23e. Did		~/	ibute to t	he cause of dea
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Completed												24a. Was				ppsy findings ava
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ToF	X	res 2] No	1	lospital:	Inpatient	2 🗆	ER/Outpatie	nt 3 DO	A Dthe	4 🗆 Nursing H	lome 5 🗆 Res	idence	6 (MOthe	er (Specif	SCENE
		er of Dea latural	ith 5 🗀 Per	ndina	28a. Date	of Injury		28b. Time o	of 2	3c. Injury Work	at	28d. Describe	how injur	y occurr	ed	unk
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Certifications	4 🗆	Suicide Homicide	det	emined	28e. Plac build	e of Injury ding, etc.	y - At ho (Specify	ome, farm, st	reet, factory	, office		28f. Location (Street an wn, State	B2T	East	Patric
					found	d_at	hon	ie				lpt.D, F	'rede	rick	., Ma	ryland
edical	29a. Ce	eck only	1☐ Certi: 2☑ Medi	fying Phy cal Exami	ner: On the b	basis of e	xaminal	wledge, dea tion and/or in	th occurred anvestigation,	at the tim in my op	e, date and place inion, death occu	, and due to the irred at the time,	cause(s) date and	and mai I place, a	nner as s	tated. the cause(s)
Med			d title of cert		and mar	nner state	∌ d.									
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ORIGINAL

Maryland Montgomery Burtonsville 10g. Citizen of What Country? 10g. Street and Number 10d. Zep Code 10g. Citizen of What Country? 14762 McKnew Rd 20866 United State 14762 McKnew Rd 10d. Zep Code 10g. Citizen of What Country? 14762 McKnew Rd 10d. Zep Code 10d. Citizen of What Country? 14762 McKnew Rd 10d. Zep Code 10d. Citizen of What Country? 14762 McKnew Rd 10d. Zep Code 10d. Citizen of What Country? 12d. Was Decedent of Hispanic Origin? (Specify Ves or No-Ill Yes, specify Cuban, Mexican, Puerfor Rican, etc.) 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 10d. Citizen of What Country? 14762 McKnew Rd 14	0074
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10c. City, Town or Location 10c.	
Tanya Garland 17. Father's Name (First, Middle, Last) James Winfrey 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda May Winfrey — Spouse 14762 McKnew Rd., Burtonsville, MD 20866 20a. Mathod of Disposition 12 Burial 2 Cremation 3 Removal from State 13 Code, Place of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 20b. Place of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 20a. Mathod of Disposition 12 Burial 2 Cremation 3 Removal from State 13 Code, Place of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 20a. Mathod of Disposition 12 Burial 2 Cremation 3 Removal from State 13 Code, Place of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 20a. Mathod of Disposition 12 Burial 2 Cremation 3 Removal from State 13 Code, Place of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 20b. Place of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 20c. Location - City or Town, State Zip Code) Maryland National Mem. 6/29/2005 Laurel, MD 22a. Partl Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Consulting in death) 2a. Partl Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Consulting in death) 2b. Due to (or as a consequence of): 2a. Code of Disposition (Name of cemetary, crematory or other Pear's Name (First, Middle, Maiden Sumame) 2b. Due to (or as a consequence of): 2c. Due to (or as a consequence of): 2c. Due to (or as a consequence of): 2c. Due to (or as a consequence of): 2c. Due to (or as a conse	e City Limits
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I.	of death?
To see the state of the state o	Unknown
Topology of the part of the pa	gs available of cause of
I Inpatient 2 ER/Outpatient 3 DOA United 4 Nursing Home 5 Residence 6 Ther (Specify)	scene
27. Manner of Death 1 Inpatient 28b. Time of Injury 28b. Tim	
2 Accident investigation (6) 24/05	
See See See See See See See See See See	Cle ivic
29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Amount of Day Year) 29b. Signature and title of certifier (Month Day Year)	
OCME)
June 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Psirl) 1 Penn Street Baltimore, Maryland 212	
UP S, E. HUGHIO	01
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature 2. Registrar	

			1 - For State of Maryland / Dep	partment of Health and Mertificate of Death		ene	
	Phýsici /Medio		1. Decedent's Name (First, Middle, Last) Joan Jennings Zgorski		2. Date of Death June	2005 14, 2005	32 time of peat 7 11:40 a M
	Examin	er	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Art	undel
	Funeral Director		5. Social Security Number 206-26-0348 Contract Number 206-26-0348 Contract Number 3. Age (In yrs. last birthday of the second of the sec	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan. 12	9. Birthn Cour	place (State or Foreign ntry) PA
	ne Maryland 8a-f show officed at	ector	10a. State 10b. County 10c. City, Town or L MD Anne Arundel	Annapolis			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	s 23a or 2	Funeral Director	106. Street and Number 1106 River Bay Road	10f. Zip Code 21401		J. Citizen of What Cour USA	
9036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Midical Examination until be muffled at anote.	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, White, Specify:	
Baltimore, Maryland 21215-0036	d within 72 h giene. er than "natu ine Medice	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation of kind of work done during most of work DO NOT use retired) Accountant	ing 16	Accounting	
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8760,	Physician /Medical Examiner and the prize nand the prize transit the prize transit tra	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Cancer	or respiratory arrest	,	Approximate Interval Between Onset and Death
.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	2 No 3 Prob	ne cause of death?
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Vital	Physician: Th this certificate ral director, pag) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 postient 2 ☐ FR/Outpatie	Other	h (Check only one)		
ion of	ding After fune	atlon: To	1 Yes 2 No	and SELDON 4E INdisting Ho	me 5 ☐ Residenc 28d. Describe how	e 6 □Other (Specify injury occurred	1)
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, S		
	To the Hospital or within 24 hours effet To the Funeral Discompletely filled in	ledical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	and due to the caus red at the time, date	se(s) and manner as s a and place, and due to	ated. the cause(s)
	To with con	Σ.	29b. Signature and title of certifier Curles Harris, M.	29c. License number 1 53300	5	Date signed (Month,	5
			30. Name and address of person who completed cause of death (Item 23a) (Type Cut H 5 Hairs MD 588 Bests	e, Print)	-11 Hun	apoles w	102149
	Sta Registi		31. Date filed (Month Ny, Year) 2005 32 Aegistrar's Signature	book			

State Registrar

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Company Comp					Huspitch		B					N/L	
Top Steel and Number Top College Top C				214 22 8285- 10	7. Age (In yrs.					n. (Mont	of Birth h, Day, Yea	9. B	irthplace (State or Foreign Country)
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			Decedent's Name (First, Middle, Last)		2. Date of Death	No. 2005 2 Time of San 1
	Physicia		Connie N. Bell		Month July 12	Day Year 10:45 P.M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Anne Arundel General Hospital	Annapolis		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	9. Birthplece (State or Foreign Country)
	Director		234-48-2824 72 Yrs. Usual Residence of Decedent	J	June 3, 1	933 West Virginia
	and wo		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	Mary -f sh	tor	Maryland Queen Anne Stevens	vri11a		1 □ Yes 24Q4No
	r 288	Directo	10e. Street and Number	10f. Zip Code	10g.	Cilizen of What Country?
	th wit	alD	110 Cat Tail Court	21666	U	nited States
	ems erra	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 25 No Specify:		Specify: White
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פ	e file al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, Mai	den Surname)
<u>a</u>	uld b Ments nrked ntice	ToE	Millard Keyser	Mo11y	Adkins	
Maryland	2 sho and Is ma			ling Address (Street and Number or Rural		
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Baltimore,	ges 1 If of H or ot		I Burial 2 Ucremation 3 Lynemoval from State	ematory or other place)	9	. Location - City or Town, Slate
Ë	t. Pa rtmen rtant: njury		`4 □Donation 5 □Other (Specify) Woodmere	200 Mem. PK.	15 Hu	ntington, W.Virginia
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is proportant; frem 23 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, it.e. Modical Experiment matter matter matter any or one.			22. Name and Address of Facility Cirkley-Ruddick Fune 21 Crain Hwy. S.E.		
1			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	chitraccienca	1 Pre	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	elactaria		
		-	Sequentially list conditions, if any, leading to immediate b.	erallare		
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	Phy ar this aral d	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time	4 Nursing Home	e 5 ∐ Residence 3d. Describe how i	e 6 Other (Specify)
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	tal or A 's after al Direct ed in by	Cert	4 Homicide building, etc. (Specify)		City or Town, Si	rare)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, dea 2 ☐ Medicel Examiner: On the basis of examination and/or in manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	d due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	othe othe omple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
)	->-0		· Centre Harris (10)	053306		7/13/05
	n		30. Name and address of person who completed cause of death (Item 23a) (Type			11'11'07
_	12		Cultis Harris, MD 900 Best	gate Rd Ste 300.	Hnnap	olis, MD 2-140
	Sta	100	Sz. Marshar S Signature		7	
	Registr	ar	JUL 1 4 2005	back		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Louise E. Burhorst Ju1y 12 2005 1:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Homewood Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months 217-12-3940 82 Director 9. 1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28e-f show ant: If item 27 is marked other than "natural", or items 23a or 28e-f show Lity or other traumatic avent. The Medical Exercitiest and the notified at my or other traumatic avent. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4410 Falls Road 21211 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Bakery Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Davis Nora Burke ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Myers Daughter 4410 Falls Road, Baltimore, Maryland 21211 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Baltimore—Washington 7/16/2005 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2x Cremation 3 ☐ Removal from State urtment c ortant: I 5 ☐ Other (Specify) Laurel, Maryland ¹ 4 ☐ Donation Crematory permit.
Departn
Imports
any inju 21. Signat Funeral Service Licentee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Huportersic Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit ellito ichsetes Due to (or as a consequence of): Box 68760, the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Vunknown been 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No page death? 1 ☑ Yes 2 ☐ No certificate 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0059056 MO 12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dalleet MO 1600 West MT Royal 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUL 1 4 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bessie Mae Bracey 2005 8 11:00p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3510 Bellevale Avenue NA Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🕏 F 217-22-4445 Yrs. Director S.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ "" any fijury or other traumatic event." 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ty∏Yes 2 □ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3510 Bellvale Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Nursing Varies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hughey Stevenson Aberta Woodard ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Scott Daughter 3105 Kentucky Ave., Baltimore, Md. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

✓ Burial 2 □ Cremation 3 □ Removal from State 7-14-05 Baltimore Cem. ` 4 Donation 5 Dother (Specify) Baltimore, Md. 21. Signature of Funecal Service Licenşee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GASTRIC CARCINOMA ROBABLE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: certificate 2 □ No 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) axaminer Other: 4 Nursing Home 5 Phesidence 6 Other (Specify, ို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) p 4 T Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier om 23a) (Type, Print)

560/ LOCH RAVEN BUD. BALTIMORE, MAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERBERT PRIEDMAN MO. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 4 2005 Registrar

ian	State Registrar Decedent's Name (First, Middle, Last)			ertificate d	. 50401		Date of Death	No.2 () (Year	3. Time of Death
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Dire	10e. Street and Number			10f. Zip Cod				Citizen of W	hat Cour	ntry?
erai	4112 Taunton Driv	12. Was Decedent E	ver in U.S. 13	20705		nin? (Specifi		.S.A.	- Americ	an Indian.
by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		I. Was Decedent of If Yes, specify C		, Puerto Ric	an, etc.)		, White,	etc.
ted	15. Decedent's Edu	ıcation	16a. Dec	edent's Usual Oc	cupation		161	. Kind of Bus		
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	21. Signature of Funeral Service Licens	\sim \sim	101103	22. Name and Ad Donaldsc 313 Tali	n Funei	ral Ho	me, P.A	ryland	207	07-4389
ai Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as a b. Due to (or as a c.	consequence of): consequence of):							Onset and Death
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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			For	State of Marylar	id / Depa	artment of H	ealth and i	Mental Hygi	ene	
			1 - State Registrar		Cei	rtificate of l	Death	Re	g. No.2015	22981
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	/Medic		KATHRYN			SAHR)	1	10 2005	
	Examin	er	4a. Facility Name (If not institution, give			_	Location of Deat	h	4c. County of Dea	
			JOHNS HOPKINS			BALTIM				RE CITY
	Funeral		5. Social Security Number 6. S 214-14-1423		last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Bin	thplace (State or Foreign buntry) VIRGINIA
	Director		Usual Residence of Decedent		7 113.			MARCH 15	, 1921 W	15+ VIRGINIA
	land ow		10a. State 10b. County	10c, Cir	ty, Town or Lo	cation				10d. Inside City Limits
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	with the Maryland a or 28a-f show Les notified at	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code		10	g. Citizen of What Co	ountry?
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5	hould d Me mark matic	2	19a. Informant's Name/Relationship	Type Print)					City or Town, State, 2	Zin Code)
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	SI		30. Name and address of person who	completed cause of death (iter	n 23a) (Type.	Print) A	NIRudh	SRINA	RAN MID.	2005
	9		5505 HOPK	completed cause of death (iter	WCIR	Leve	BALTIM	TORE !	10 21	224
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	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) WINIAM HENRY BEALE SK 4a. Facility Name (If not institution, give street and number) 4b. City, Town, of	or Location of Death	2. Date of Death Month July 9	Day Year 2005- 4c. County of Death	9:45 p. M.
	Examir Funeral	ier	JUHNS HUPKINS HOSPIFU 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) If Under 1 Year	nuxe	B. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
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	e Maryla Ba-1 ehor	Director	M.D N/a BALLIMORE				0d. Inside City Limits 1/☑Yes 2 □ No
	th with the 23a or 2	al Dire	10e. Street and Number 10f. Zip Code 2/2.	43	10g.	Citizen of What Cour	ntry?
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	To the To the complet	M	Mino D Miles Gresett, SUD DY	lo 4. 4.4	7	Date signed (Month,	
	le		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2323 DH	leans St,	Bult, M.	021224
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

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8760 (\$	ate be executed any sicien and he burial-transit	dical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nditions, mediate rlying injury .ast	b c d	· ·	or as a cons	equence of):	ND	RUM	16							
P O Roy 68760	at the death certification by the attending pritached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 if Yes 2 if Yes 2 if Yes 2 if Yes 2 if Yes 2 if Yes	months?	230	1 ☐ Live b	come of precinth 2 Figure 2 in the contract time on the contract time on the contract in the c	etal death	3 □Ectopio 5 □ Other		су			_	1	ate of delive	ry Day Year	
	quires that n signed b	by	Part II. Dther signifi	olucione de la conditiona de la conditio	el V	buting to de	eath but not i	esulting in the	underlyin	g cause g	jiven in Pa	ırt I.		id tobac	2 X lo		e cause of death	
Ç	e law requir has been si je 2 should l	Completed	PiA	bete	1									√as an	24b	. Were autor	sy findings avail	lable
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<u> </u>	sicien: The certificate hi	Be	25. Was case refer examiner?	1	V	spital:	//E					ace of Dea	ath (Check or	nly опе)				
Ę.	Phys r this ral dir	-: To	1 Yes 2 X			1 Au		☐ ER/Outpat 28b. Time		DOA		Nursing H	lome 5 R)	
2	nding P ath, r; After I e funera	ation	1 Natural 2 Accident	5 Pendin		(Mont	of Injury h, Day Year)	Injun		28c. inju W	ork? ∐Yes 2	□No			.,u.y cooc			
Division of Vital Records	ai or Attendia s after death, if Director; A od in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could r determ	not be ined	28e. Place buildir	of Injury - Al	home, farm,	street, fact	tory, office)			n (Stree Town, S		iber or Rura	Route Number,	
	To the Hospitai of within 24 hours at To the Funerei D completely filled it	edicai	29a. Certifier (Check only one)	1 Certifyin 2 Medical I	g Physic Examine	r: On the ba	isis of exami	nowledge, de nation and/or	ath occurre investigati	ed at the ion, in my	time, date opinion, d	and place death occu	, and due to irred at the tir	the caus ne, date	e(s) and n and place	nanner as st , and due to	ated. the cause(s)	
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	1		7 / / /	isch	W	WI	M			1	7	1100	2	(27.	- 13	-2005	_
	7		30. Name and addre	Min D	who com	pieted chus	or death (I	em 23a) (Typ	Print)	(00	69	N.C	han	les.	5+	7500	120 V	10
	Sta Registr	· ·	31. Date filed (Monta	h, Day, Year)	2005	100	egistrar's Sig	nature	bade				/			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year **Physician** Thelma Brown 2005 /Medical July 11, 5:58 P 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Genesis Eldercare | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y 12-25-1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔏 F 218-64-0486 50 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show ir than "natural", or itams 23a or 28a-f show the Modical Examinat must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2725 Walbrook Avenue 21216 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after connot of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or Itar Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the second se 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10 \end{array}$ College (1-4or 5+) Home Care Provider Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Claude Brown Callie Jordan traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Teal/Sister 2406 Tionesta Road Apt 2C Baltimore, MD 21227 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑8urial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ö 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 07-15-05 Lansdowne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 Fart 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eyen line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumone /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): o the Hospital or Attending Physician: The law requires that the death certificate ba executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ eq Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗀 No 2/2 No 1 Yes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ihis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

ORIGINAL

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

th. Day. Year)

31. Date filed (Month.

2) 17 Hamman & Ferry Rel Borro

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		1 - For State Registrar	State of M	Maryland / Dep	artment e <i>rtificate</i>			nd Me	, ,	iene	2005	22000
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Funera Directo		051-36-8365	1 □XM 2 □ F	62 Yrs.	Months	Days	Hours	Min.	3. Date of Birth (Month, Day, L-26-19	Year)	NY	lace (State or Foreign stry)
		Usual Residence of Decedent							1-20-19	43	NI.	
rylan		10a. State 10b. County		10c. City, Town or	Location						1	0d. Inside City Limits
Be-1 s	Director	MD Anne Ar	undel	Glen Bu	rnie							1 ☐ Yes 2X No
or 2	Dire	10e. Street and Number			10f. Zip				1	0g. Citize	n of What Cour	itry?
death with the Maryland ms 23a or 28e-f show		8923 Park South				1061		. 0 / 0		USA		
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72 hours af	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Date:	l l	1 ☐ Yes 2	2 XNo	Specify:			S	pecify: Wh	ite
within 72 hours after ene. then "neturel", or ite he Medical Exernand	ted	15. Decedent's	Education	16a. Dec	edent's Usua ve kind of wor	I Occupa	tion	-6		16b. Kínd	of Business/Inc	dustry
within 7	npie	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	life	. DO NOT us	e retired)	uring most o	or working		North	nrop Gr	umman
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D # D %	/Me	IF FEMALE:	23c. If yes, outcor	no of prognance								
attanoin for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	Ectopic pro					230	 Date of delive Month 	ory Day Year
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4 2 a	lg.	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying ca	ause give	n in Part I.		23e. Did tob	pacco use	contribute to the	ne cause of death?
VITAI HECOTAS, itcien: The law requires t certificate has been signe rector, page 2 should be.	d by	EMPHYSE.	MA						1 05 Ye	es 2 🗆 1	No 3 ☐ Prob	ably 4 Unknown
w require been sign	iete								24a. Was a	0	24b Were auto	psy findings available
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g Phys g Phys ter this neral dia	Ë	27. Manner of Death	28a. Date of I			8c. Injury Work			d. Describe ho			,
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DIVISION OT VITA To the Hospitel or Attending Physicien: within 24 hours eiter death. To the Funerel Director: Atter this certific completely filled in by the funeral director.	edical	(Check only 2 Medical E	xaminer: On the basis	st of my knowledge, de of examination and/or	ath occurred investigation.	at the time in my op	e, date and inion, death	place, an	nd due to the ca	ause(s) ar ate and pi	nd manner as s lace, and due to	tated. the cause(s)
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11)	30. Name and address of person w		Soll R	11 CH1	E (YWY	PA	SAUC	VA	14	2005
	State	31. Date filed (Month, Day, Year)										
	istrar	JUL 1:2	2005	strar's Signature	hoods							

			State of Maryland / Dep	artment of Health and Mertificate of Death	, ,	ene 9. N2 0 0 5	22000
	Physici	an	1. Decedent's Name (First, Middle Last) Sofiya Baranous kaya	Timeate of Beatif	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July	4c. County of Dea	
			Sinai traspital of Paltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore	0.0		N/A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 20–33–3907 1 M 2 T F 99 Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, DEC. 20,	1905	thplace (State or Foreign buntry) UKRAINE
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or U	ocation			10d. Inside City Limits
	8a-f sh	Director		TIMORE			1 ☐ Yes 2 No
	a or 2		16 OLD COURT ROAD, APT. 722	10f. Zip Code 21208	10	g. Citizen of What Co	UKRAINE
	r death	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
036	urs afte al', or it	by	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 A No If Yes, Give Year or Dates:	1 Yes 2 No Specify:		Specify:	WHITE
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212	d withir giene. ar then	omo	Elementary/Secondary (0-12) College (1-4or 5+) NUR:			NURSING	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or items 23a or 28a-f show eumetic event, the Medical Exertment he recilied at	Be	17. Father's Name (First, Middle, Last) JACOB BARANOV	18. Mother's Name SKAYA SARA	(First, Middle, M		BTAINABLE)
ary	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marks any injury or other treumetic. 0009.	T ₀	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rura		City or Town, State,	Zip Code)
	1 and 1 Health em 27		BORIS SHARGORODSKY / GRANDSON 6939 20a. Method of Disposition 20b. Place of Disp			RE, MD 212	
altimore,	Pages nent of I ant: if its		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	omatory or other place) N CHIZUK AMUNO 7/13		BALTIMOR	
Balt	permit. Departr Importa			22. Name and Address of Facility SOL 8900 REISTERSTOWN F	LEVINSO	ON & BROS.	, INC.
			23a. Parti. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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P. O.	that the de ed by the a detached t	hysic	1 ☐ Yes 2 ☑No 4 ☐ Freghant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to s 2 🗆 No 3 🗀 Pr	o the cause of death?
Vital Records,	The law re ate has bee page 2 sho	Completed			24a. Was an autopsy perform	ed2 prior to death?.	utopsy findings available completion of cause of
/ital		BeC	25. Was case referred to medical examiner?	26. Place of Death		☑No 1 ☐ Yes	2 □ No
	ding Phyei h. After this c funeral dir	n: To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ EF/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time		ne 5 🗆 Resider 28d. Describe hov	nce 6 Other (Spe winjury occurred	cify)
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•	To ti withii To ti	M	29b. Signature and title of certifier	29c. License number D 25379	l l	d. Date signed (Mont	
•	27		30. Name and address of person who completed cause of death (Item 23a) (Type Steven L. Lotte M.D. 2401 W. Belved		ive Mo	2. 2121	5
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 4 2005 32 Registrar's Signature				

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			Negistrar Necedent's Name (First, Middle,	Last)		rinoate or	Death				. Time of E	Death
	Physici		George		Ch	h.a		Month	Day	Year		М
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)	CIT		or Locetion of D				1:48	_a
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	aryla ehov	<u></u>	10a. State 10b. County		ly, Town or Lo	ocation					,	
	he M	ecto	Maryland Anne	Arundel Ar	mapoli	7			40 000			
	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or items 23e or 28e-f ehow ant, tre M. Alcal Examili or mart be notified.	Completed by Funeral Director		D-4 #207					-	vnat Country ?		
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936	urs al	by	3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify	· White	5	
21215-0036	72 ho	ted	15. Decedent'	s Education	16a. Dece	dent's Usual Occup	pation	working	16b. Kind of Bu	ısiness/Indust	ry	
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Maryland	12 st h and 7 is n treun		19a. Informant's Name/Relationsh		dien beer							
	1 and Health em 27 Ither tr		Mary Charuhas 20a. Method of Disposition	20b. I	7101	Bay Fron	t Drive	#307, An	napolis,	MD 21 City or Town	403 State	
JO.	Pages nent of ant: If it		1 ⊠Burial 2 ☐ Cremation	3 □Removal from State	emetery, cre Tingo	matory or other pla	(CO) 7 /	6/05				a
Baltimore,	그 든 분 등		 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L 									7
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	- 4		23a. Part1: Enter the disease, or o	complications that caused the deal		_				Ap	proximate	
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687	physics the		·	d								
×	certif nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant						23d. Dai	te of delivery		
Вох	d for	ciai	in the past 12 months?	4☐Pregnant at time of c			У			-	y Ye	ear
Ö.	Physicien: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	by Physician/Med	9 Unknown	9Ll Unknown								
S, P	ss tha	by P	Part II. Other significant condition	s contributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use cont	ribute to the c	ause of de	ath?
ord	equire en si ould b		- Cu	0000000	Zue			11	Yes 2□No	3 Probably	/ 4 □Ur	ıknown
ecc	law r as be	pie		· · · · · · · · · · · · · · · · · · ·					an 24b. V	Were autopsy	findings a	vailable use of
= =	The sate h	Completed									No	
Vital Record	cien: sertific ector,	Be	25. Was case referred to medical examiner?	Monitol		04						
	Physithis directions at direction	5 To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2								
LO	ding h. After funer	tion	1 Satural 5 Pending					280. Describe	now injury occurr	90		
Division of	Attending It death. ector: After by the fune	fica	3 Suicide 6 Could no	at ho	ome, farm, sti		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	28f. Location (Street and Numb	er or Rural Ro	oute Numb	er.
<u>S</u>	after after Dire d in b	Certification:	4 Homicide	building, etc. (Special	(y)	, , , , , , , , , , , , , , , , , , , ,						
	hours hours nere y fille		29a. Certifier 1 ertifying	Physician: To the best of my kno	wledge, deat	h occurred at the ti	me, date and pi	ace, and due to the	cause(s) and ma	nner as stated	d.	
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medicai	(Check only 2 Medical E	and manner stated.	ition and/or in	vestigation, in my	opinion, death o	ccurred at the time,	date and place,	and due to the	cause(s)	
	To T To T	Σ	29b. Signature and title of certifier			29c. Licens	se number	2, 0	29d. Date signed	(Month, Day	, Year)	_
				and	N		00518	14.1	01.0	6.7	ws	
	10		30. Name and address of person w	no completed cause of death (Iter	n 23a) (Type,	Print)	had S	te 100 F	Most	5 M	2	TK1
	ט'י) Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Signa	ature /	-		1000		A	JA	90
	Registr		JUL 1 4 20	105 Sente to	Special	W.				V		
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-			1 - For Stata Registrar	State of Mar		artment of H				
100	Physic /Medi		1. Decedent's Name (First, Middle, Last Joseph Luther	Clements				2. Date of Deat Month July	Day	05 3.2m2r6ag 2005 14:45 M
	Exami		4a. Facility Name (If not institution, give 223 Palmetto Driv	street and number)		4b. City, Town, or Edgewo	Location of Death		4c. County of	
t	Funeral Director		5. Social Security Number 217–96–8818 Usual Residence of Decedent	x 7. Age (M 2□F	In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day July 15	, 1965	Birthplace (State or Foreign Country) Md.
	Maryland n-f ahow	tor	10a. State 10b. County Md. Harford	1	oc. City, Town or Lo Edge					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	th with the 23a or 286	al Director	10e. Sireet and Number 233 Palmetto Drive	2		10f. Zip Code 21040		10	0g. Citizen of W	/hat Country?
920	72 hours after death with the Maryland "natural", or Itama 23a or 28e-f ahow idical Examinat the putilised at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l	Vas Decedeni of Hi f Yes, specify Cubai □ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, k, White, etc. White
21215-0036	s within giene. r than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 yrs.	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired; rrectiona	luring most of work)	ing	State of	of Maryland
Maryland	should be filed nd Mental Hygir marked other umatic avant, I	To Be C	17. Father's Name (First, Middle, Last) Berkley Clement				18. Mother's Nam Dorot	e (First, Middle, M ny Cline		s)
	s 1 and 2 shou if Health and M Item 27 Is mar other traumati		19a. Informant's Name/Relationship (Ty Joel Clements 20a. Method of Disposition	brother		g Address (Street a	w Rd. Ba	lto. Md.	21221	
Baltimore,	Page ient o int: If iry or		1 ☐ Burial 2 ②Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 2(. Signature of Funeral Service License	emoval from State	Bayview C	rematory of other place rematory	20	005	Baltimo	Dity or Town, State
Ba	permit. Departm Imports any inju		23a. Part. Enter the disease, or complication of the disease of the di	SI		Name and Address Connelly 7110 Soll	ers Polni	Ra. 212	222	
68760,	Physician be executed / Medical Examiner s the private transit	edical Examiner	shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		onsequence of):	tnound	to hea	d		Interval Between Onset and Death
P.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnanl in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 🗍	Ectopic pregnancy Other (specify)			23d. Date Montl	of delivery h Day Year
ords, P	The law requires that the tie has been signed by th page 2 should be detache	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the un	derlying cause giver	n in Part I.	23e. Did toba	-1	oute to the cause of death?
Division of Vital Records,	iicien: The law ru certificate has be rector. page 2 sh	e Completed	05 Who was a facility					24a. Was an autopsy performe	prie	ere aulopsy findings available or to completion of cause of ath? Yes 2 \sum No
\equiv	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	ospital:	2 ER/Outpatient	04-	26. Place of Death			(Specify) SCENE
ision o	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director. page	Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye July 11, 2005	28b. Time of Injury	28c. Injury a Work? 1 🗆 Ye	at 2 es 2. PNo	28d. Describe how	vinjury occurred	f
<u>></u>	Hospital or A 24 hours after Funeral Directely filled in by		4 Homicide determined	28e. Place of Injury - building, etc. (S	home		-	223 Palme	State) Drie	or Rural Route Number, Lagewos Opta
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2X Medical Examin one)	ician: To the best of m er: On the basis of exa and manner stated.	amination and/or inve	estigation, in my opii	nion, death occurre	and due to the cau ed at the time, dat	ise(s) and mann e and place, and	ner as stated. d due to the cause(s)
)	To T Co E	W	29b. Signature and title of certifier Journal States	ze & M	0	29c. License OCI		290	July 12	Month, Day, Year) 2, 2005
	0			nberg 1	(.D.	rint) 111 Pe	enn Stree	et Balti	more, M	Maryland 21201
	Sta • Registr		31. Date filed (Month, Day, Year)	32. Registrar's	signature	and a				

			1 - For State Registrar	State of Marylar		artment o			nd Me	, ,	iene	000	~	
	Physic		Decedent's Name (First, Middle, Last MEYER	M.		(CARE	DT N		2. Date of Deat Month		OS ^{Year}	3. Zme 2	D M
A. C. C. C. C. C. C. C. C. C. C. C. C. C.	/Medi Examii		4a. Facility Name (If not institution, give	street and number) AVENUE APT.		4b. City, To	wn, or L	ocation of	Death			N/A)	<u> </u>
	Funeral Director		5. Social Security Number 6. Se 212-18-7027 15	7. Age (In yrs.	**	If Under 1 \ Months D	Year Days	Hours	Min.	3. Date of Birth (Month, Day,	1907	9. Birth Cou	place (State intry)	or Foreign
	ath with the Marylan 23a or 28a-1 show	Director	MD N/A	10c. Ci	y, Town or Lo	TIMORE							^	City Limits
36	within 72 hours after death with the Maryland sne. than "natural", or Items 23s or 28s-f show is Medical Examiter marker rollined at	Funeral	6210 PARK HEIGH 11. Marital Status 1 Never Married 2 Married	TS AVENUE #70 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:	.S. 13. V	Vas Decedent f Yes, specify	t of Hisp Cuban,	2121 Danic Origin Mexican, F		ify Yes or No- can, etc.)		ace - Amer lack, White	USA ican Indian,	
21215-0036	be filed within 72 hours after de ital Hygiene. d other than "natural", or Items event, its Medical Examinal	Completed by	3 🛣 Widowed 4 □ Divorced 15. Decedent's Edu. (Specify only highest grad Elementary/Secondary (0-12) 5	cation e <i>completed)</i> College (1-4or 5+)	16a. Deced	lent's Usual C kind of work of DO NOT use r	ocupati	on	of working	7	16b. Kind of	Business/li	ndustry	CITY
Maryland	should be filed and Mental Hyges merked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) HARRIS		CARI	DIN		ANNA	1	First, Middle, N	faiden Suma	ame)	CHE	
	1 and 2 s Health ar am 27 is ther trau		19a. Informant's Name/Relationship (T) HOWARD CARDIN / 20a. Method of Disposition	SON 20b. F	10 E.	MULBE	RRY			BALTIN		MD 21	202	
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 🂢 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	BETI	H TFILC		TER		7/13/ SOL		WOOD	LAWN,	MD	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	uence of):	3900 RE	f dying,	EKSIU such as ca	IWN K	OAD - F espiratory arre	YTKESV st,		MD 21 Approximatinterval Bet Onset and	te tween Death
P.O. Box 68760,	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical E	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do	ncy death 3 eath 5	Ectopic pregn Other (specify	y)					ate of deliver	•	Year
Records, F	w requires that been signed should be def	by	Part II. Other significant conditions cor BLADDEA CA	tributing to death but not resu	ulting in the un	derlying cause	e given	in Part I.		23e. Did toba	_		ne cause of d	1
Vital Rec		e Completed	25. Was case referred to medical					C Diana			ed? No	prior to co death?	psy findings mpletion of c 2□ No	available ause of
Division of Vi	ding Phys n. After this funeral di	ation: To Be	examiner?	ospital: 1	ER/Outpatient 28b. Time of Injury	28c. l	Other: Injury at Work?	4 Nursir	ng Home 28d	5. Residen 1. Describe how	ce 6 🗆 Oth		y)	
Divis	ital or Attendrus after deatling after deatling the field in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	")	et, factory, off	ice		28f.	Location (Stre City or Town,	State)			ber,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Director Completely Funeral Di	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examir 29b. Signature and title of certifier	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inve	occurred at the estigation, in n	ny opini	on, death o	lace, and occurred a	at the time, dat	ise(s) and m e and place, d. Date signe	and due to	the cause(s	,
i D	4		^/	TREPOING P	1725(C) A 23a) (Type, P				38	Suite 1		1		
	Sta	te	PETEL P. STAM 31. Date filed (Month, Day, Year)	32. Segistrar's Signat	3320	Bello	NA	AU	re !	Suite 1	20 1	Dwg.	on My	11204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:30 P M July 10 2005 Francis Henry Cobb /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Brighton Gardens of Tuckerman Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 25, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 6. Sex XXM 2□F Days 1913 North Carolina Director 579-44-4081 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Maryian nent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "naturel; or items 23a or 28e-f show ury or other theumatic event, The Medical Expriment must be multilled at 1 ☐ Yes XX No Brookeville Maryland Montgomery Direct 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 3420 Forest Wood Drive 20833 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) American Red Cross Manager of District Chapter 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bessie Ophelia Ives ٥ John Leonard Cobb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brookeville, Maryland 20833 John L. Cobb (Son) 3420 Forest Wood Drive; 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 2005 XXBurial 2 Cremation 3 Removal from State 16, permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Spedity) Rockville, Maryland Parklawn Memorial Park 22. Name and Address of FacilityLoudon Park Funeral Home Signature of Funeral Service Licenses 3620 Wilkens Avenue Baltimore, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition esulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of). **Examiner** Amyotrphic Lateral Sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Hypertension attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Coronary Artery Disease IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2XXNo Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy perform 1 Tes 2∕XNo the Hospitel or Attending Physiclen: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo 2 this After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation XXNatural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / I in by the f 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour.
I the Funeral Directory filled in by determined 4 | Homicide XX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai within 2 and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, July 12, 2005 D30132 d address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Ghosh, M.D.,

JUL 1 4 2005

31. Date filed (Month, Day, Year)

14804 Physicians Lane, #221;

32 Registrar's Signature

Rockville, Maryland 20850

	1 - For State Registrar		-	ertificate of		ental Hygid	J. No. 2005	0000
	Decedent's Name (First, Middle, Last	st)				2. Date of Death Month		3 Time of Death
Physician /Medical	Chris Carroll	Coffelt				JULY	7, 2005	11:06P. M
Examiner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death	
# 1	70 W/B @ SOUTH ST		(In yrs. last birthda	FREDERIO	CK If Under 24 Hrs.	8. Date of Birth	FREDERIC 9. Birth	K place (State or Foreig ntry)
Funeral Director		X]M 2□F	44 Yrs.	Months Davs	Hours Min.	(Month, Day,) Jan. 2,	1961 Vir	ntry) ginia
than "naturel", or iteme 23a or 28a-f show the "hadical Exercities must be notified at ompleted by Funeral Director	10a. State 10b. County		10c. City, Town or Round H					10d. Inside City Limits 1 ☐ Yes 2 🎇 No
28a- notifi	Virginia Loudoun 10e. Street and Number		Kouna n	10f. Zip Code		100	g. Citizen of What Cou	intry?
23a ol	17903 Airmont Roa	d		20141		U	J.S.A.	
erne er mi	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
Department of Health and Mental Hygiene "naturel", or Iteme 23a or 28a-f show Important; if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any Injury or other traumatic event, It a Medical Exercition must be notified at once. To Be Completed by Funeral Director	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XN If Yes, Give Year or Dates:		1 ☐ Yes 2X No			Specify:	White
yglene. ner then "nature it, tre Medical E	15. Decedent's En (Specify only highest gra		16a. De (G.	cedent's Usual Occur ive kind of work done	oation during most of workind)	ng 16	6b. Kind of Business/fr	ndustry
than	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ෟ erintendan		later Treat	ment
ent.	17. Father's Name (First, Middle, Last,)	11001	bull bup	18. Mother's Name			
arked off	Lowell K. Coffel	t			Patsy F	adely		
arma l	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street	and Number or Rura	l Route Number, (City or Town, State, Zi	p Code)
ealth m 27 i	Debbie Jean Coff	elt (Wife)			Rd., Roun			'aura Chata
if ite	20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3		1	sposition (Name of crematory or other pla	ice)		Oc. Location - City or T	
nant	4 Donation 5 Other (Special 21. Signature of Funeral Service Lices		Ebenezer C0321	Cemetery			Round Hill, 1 Home, Inc	
any le	21. Signature of Furieral Service Lices	2010	,00321				, VA 20132	•
*	23a. Part1. Enter the disease, or com shock, or hear failure. List only	plications that caused	the death. Do not					Approximate Interval Between
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*	Physici	an	1. Decedent's Name (First, Middle, Las Matthew Austin Co		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2. Date of Do	Day	Q.5	3.2 importge=9,5
	/Medi	_	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea	JULY	7, 200		11:06P. M
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100	Funeral Director		5. Social Security Number 6. S		vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth av, Year)	9. Birthpl Count	ace (State or Foreign try) ginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	cation					Od. Inside City Limits
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ထွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show may injury or other traumatic event, the Medical Exam and must be notified at once.	/ Funeral	11. Marital Status 1 X Never Married 2 ☐ Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 ☐XNo		Specify Yes or Norto Rican, etc.)	o- 14. Race Black Specify:	- America , White, e	
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Baltimore,	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, crer	natory or other plac	1	Date	20c. Location - 0	ity or Tov	wn, State
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Ba	permit. Departr Imports any inju		Margare -	1000321					, VA 2013		•
	Physician /Medical Examiner		23a. Part 1. Enter the disease of comp shock, or head failure. Est only Immediate Cause (Final disease or condition resulting in death)		ultiple	Fylurie		ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
V	\$ 15 m	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	saquense of).	-					
68760,	tificate be executed ig physicien and as the burial-transit	edical Exar	that initiated events resulting in death) Last	Due to (or as a cond.	sequence of);						
P.O. Box 6	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ £ 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont		y Day Year
S, G	res that igned b be deta	by Pł	Part II. Other significant conditions c	ontributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contril	oute to the	e cause of death?
ord	w require been sign							1 🗆	Yes 2 No 3	Proba	ably 4 Unknown
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Division of Vital Records,	al or Attending Physician: The safter death. I Director; Atter this certificate ha din by the funeral director, page	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined	(Month, Day Yea	Injury	PM 1 =	k?" Yes 2 No	28f. Location (City or To	. b . L	Valve)	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, death	occurred at the tin	ne, date and place pinion, death occ	e, and due to the	cause(s) and man	ner as stand due to	ated. the cause(s)
)	To the within 2 To the complete	W	29b. Signature and title of certifier	M. J.A	-	29c. Licens	e number		JULY 8,		Day, Year)
	3		30. Name and address of person who	completed cause of death	Item 23a) (Type,	Print)		BALTIMO	ORE, MARYL		21201
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature						
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** July COHEN ARCHIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A KESWICK NURSING HOME BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) SEP.10,1907 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Days Months MD 97 214-18-0054A Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show ?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Expedies must be notified at 1 ☐ Yes 2 ▼ No Completed by Funeral Director BALTIMORE BALTIMORE MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If I flem 27 is marked other than "" any highy or other traument. USA 21207 3210 MAYFAIR ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Amed Forces?
1 N Yes 2 No WWI 11. Marital Status WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: WHITE NAVY 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY BUILDING INSPECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLUMBERG FANNIE COHEN BENJAMIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3202 WOODVALLEY DRIVE - BALTIMORE, MD 21208 ANN HARRIS / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) #167 Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JWV MD FREE STATE POST 7/13/2005 ROSEDALE, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & B 21. Signature of uneral Service Licen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 weeks Immediate Cause (Final Congentine negut **Physician** disease or condition resulting in death) /Medical riferios clerefic Reart disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Daheles mellitus 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only only Be Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Matural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 11, 2005 reggy 41) Mr. Wardelle 013657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700W 40 4 STREET, BALTIMORE, MD 21211 17 BABELLE MACGREGOR 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ANTHONY **Physician** ROSCOE July 3:48 a M 12, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 6, 1946 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1√XM 2□ F Washington, DC 578-64-8618 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "naturel", or flems 23a or 28a-f show traumetic event, the Medical Examinating the modified at 1 \ Xes 2 □ No Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 U.S.A. 8925 Santeetlah Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ½Yes 2 □ No If Yes, Give Year or Dates: Era 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Itel any Injury or other traumetic event, the Medical Example at Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3(T) No Specify: Specify: 3.☐Widowed 4 ☐ Divorced Black Era Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager of Acquisitions Pentagon / D.O.D. Grade 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Dotothy Slaughter Roscoe A. Dixon, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellicott City, Maryland 21042 3074 Tarra Maria Way Darin A. Dixon son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Kurial 2 □ Cremation 3 □ Removal from State 7/20/2005 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD National Mem. Pk. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson FuneralHome, P.A. / M00770 313 Talbott Avenue Laurel,
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Me tasta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation nerel Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel [29a Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0060362 merce Abebe 5. Boure Imiru 30. Name and address of person who mpl-ed cause of death (Item 23a) (Type, Print) Serry 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 4 2005 Blow H. Aparle Registrar DHMH 17 Rev 1/2001

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		-	For State Registrar	State of N	/larylan		artmen rtificat			and M	ental Hy	/giene Reg. No.	2005	22000
	Physici /Medic Examin	an al	Decedent's Name (First, Middle, La	LUCA	or)				Location o		2. Date of Do Month	13 Theay	2005.	
	Funeral Director		055-20-4 154			last birthday) Yrs.	If Under Months		if Under Hours		8. Date of Bi	irth ey, Yes)	Baltimo	hplace (State or Foreign
	e Maryland ta-f show tiffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	ore		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 📉No
	sath with the	Funeral Director	10e. Street and Number 4600 Alcott Way	#101	nt Ever in II	S 13 '	10f. Zip	211		nin? (Spe	cify Yes or N		U.S.	Α.
900	72 hours after death with the Maryland natural', or items 23a or 28a-f show Iteal Examinar must be invitted at		11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Force 1 M/Yes 2[If Yes Giver Year of Date	s? ⊒ No		lf Yes, spe 1 ☐ Yes	cify Cuba 2 🛣 No	n, Mexicar Specify:	i, Puerto I	Rican, etc.)		Black, Whit	e, etc. /hite
21215-0036	within and.	Completed by	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		or 5+)	life.	dent's Usua kind of wo DO NOT us Profes	rk done d se retired	luring mos	t of workir	ng	16b. Ki	college	
Maryland	2 should be filed vand Mental Hygie Is marked othar sumatic event, II.	To Be C	17. Father's Name (First, Middle, Last Eugenio DeLuca 19a. Informant's Name/Relationship (19h Mailii	na Address	: (Street a		Bess:	(First, Middle ie Bru	no	Sumame) r Town, State, 2	Zip Code)
Baltimore, Ma	and lealth m 27 her tr		Aurora V. DeLuca 20a. Method of Disposition 1 Durial 2 Cremation 3 C 4 Donation 5 Other (Specia	- wife	te C	4600 Place of Dispo	Alco	tt Wa me of other place	ay #1	01,	Owings	Mill 20c. Lo	s, Md.	21117
Balti	permit. Pages 1 Department of H Important: if ite any injury or ot onca.		21. Signature of Funeral Service Lice	LUX		F		dt Fr Reis	inera terst	l Ch			Mills,	Md. 21117
8760, 🗡	Section 2 of the principle of the princi	Ilcal Examiner	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	line.	uence of):	7				EN SE	1		Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-Iransi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 □ Feta tat time of d	Ideath 3	⊒Ectopic p. □ Other (sp						23d. Date of del Month	ivery Day Year
<u>α</u>	w requires that t been signed by should be detai	by	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	inderlying o	cause give	en in Part I		-	tobacco u		o the cause of death?
Vital Records,		Completed									perf 1 ☐ Yes	opsy formed? 212 No	24b. Were au prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
o	ding Physician: Th. After this certificationeral director, p	n: To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 1 Inp. 28a. Date of I		ER/Outpatie		Otho 28c. Injun	9r: 4 □ Ni	ursing Hor	n <i>(Check only</i> me 5 ☐ R <i>es</i> 28d. Describe	sidence (6 □Other (Spe y occurred	cify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not t 4 Homicide determined	28e. Place of	Injury - At h etc. (Specif		M reet, factor		Yes 2□		28f. Location City or To	(Street an own, State	d Number or Ri	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C		hysicien: To the be miner: On the basis and manner	s of examina									
)	To the within 7	Me	29b. Signature and title of certifier	n ella r	n.0		1	541	U V D			July	te signed (Mont	h, Day, Year)
	6		30. Name and address of person who	LOSPITAL	CENT	rek			40ER 15TI		MEHTI	A	21133	
	Sta Regist		31. Date filed (Month, Day, Year)		istrar's Signa	Apas	Med !							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / State of Maryland / Registrer		artment of Health and rtificate of Death		giene Reg. No. 2 A A E	20000
3	Physicia		1. Decedent's Name (First, Middle, Last) ANN DAVIS			2. Date of Dea Month	Day Year	S. 20 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER		4b. City, Town, or Location of Di RANDALLS		4c. County of Death BALTIF	nore
	Funeral Director		5. Social Security Number 6. Sex 1 M XXF 7. Age (In yrs. last to 1 M XXF 6.	birthday) Yrs.	If Under 1 Year If Under 24 Hours Months Days Hours M	Ain. (Month, Da		place (State or Foreign ntry) yland
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, To MD Baltimore Red		cation			10d. Inside City Limits
	th the h	Director	10e. Street and Number	1500	10f. Zip Code		10g. Citizen of What Cour	ntry?
	ath wi	rai	203 Hammershire Rd.		21136		U.S.A.	
36	72 hours after death with the Maryland natural', or Itame 23a or 28a-f show Beal Exandruc must be molffied at	by Funerai	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, XX No If Yes, Give Year or Dates:	i	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt □ Yes XX No Specify:	? (Specify Yes or No- uerto Rican, etc.)	Specific	
2-0	n 72 hours "natural", idical Ex	eted	15. Decedent's Education 16 (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of	working	16b. Kind of Business/In	dustry
21215-0036	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. item 27 Is marked other than "natur othar traumatic evant, the Macheal	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 2	life.	Housewife		Own Ho	me
Maryland	d be fill and oth) Be	17. Father's Name (First, Middle, Last) Joseph Ninrod Battle, Sr.			Name (First, Middle,	maiden Sumame) zabeth Hor	sev
aryl	should ind Men s marka umatic	ျှ		9b. Maili	ng Address (Street and Number or			
	1 and 2 Health a tem 27 Is		Daisy M. Battle Bryant/Sister					
altimore,	0 0		XXBurial 2 □Cremation 3 □Removal from State	tery, cre	sition (Name of matory or other place)	Date	20c. Location - City or To	
Him	구두목근		4 ☐ Donation 5 ☐ Other (Specify) Johns 21. Signature at Fineral Spice Licens		le Cemetery 7			
Ba	permit. Departi Importi any Inj		trepad form		.605 Reisterst			
	Physician /Medical Examiner	er	23a. Part. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	M F		diac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence).	ce of):				
O. Box	the death certifics y the attending pt ched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)		23d. Date of delivership Month	ery Day Year
<u>α</u>	quires that the de in signed by the a uld be detached f		Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause given in Part I.		obacco use contribute to t Yes 2□No 3□Prot	~
of Vital Records,	ysician: The law requir is certificate has been si director, page 2 should	Completed by				24a. Was autop perfo 1 Yes	prior to co death?	psy findings available mpletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Other	Death (Check only o		
on of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the tuneral director.	ition; To	1 Yes 2 No Prosperior 2 ER/6 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Naccident investigation	outpaties o. Time o Injury	A 20 DOX 40 Housin	_	dence 6 Other (Special now injury occurred	y)
Division	al or Attandi s after death. if Director: A id in by the to	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, st	reet, factory, office	28f. Location (S City or Tox	Street and Number or Rura vn. State)	al Route Number,
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.					
	To the Ho within 24 To the Fu	Me	29b. Signature and the of certifier		29c. License number		29d. Date signed (Month,	Day, Year)
	I,		15010		1)40 (0)	6	2=211 3	WU5
	N		30. Name and address of person who completed cause of death (Item 23 A V V E RAHALLI M HARIST 31. Date filed (Month, Day, Year) 32. Registrar's Signature	t -	Print) NORTHWE 5401 OLD (TAL CES	D 21133
	Sta Registi		JUL 1 4 2005 Roma D	× A	Carle			

		1	For State Registrar	State of Ma	ryland /	-	rtment tificate				lental Hy	-	20	05	23000
Dh	ysicia	-	1. Decedent's Name (First, Middle, Las	t)							2. Date of D Month		ay	Year	3. Time of Death
	ysicia Nedica	ı I	Vivian Louise								JULY			005	12:52P
Ex	amine		ta. Facility Name (If not institution, give GOOD SAMARITA	N HOSPI				TI	MOR	E			tc. Count		
Fun Direc			5. Social Security Number 6. Security Number 214-24-1917 Usual Residence of Decedent	x /. Age	(In yrs. last	Yrs.	Months [Days	If Under Hours	Min.	8. Date of Bi (Month, O Dec. 3	ay, Yea	^(r) 926	Col	nplace (State or Forei untry) ginia
the Maryiand 28e-f show	colling at	_	10a. State 10b. County Maryland None		10c. City, To Ba1	own or Loc									10d. Inside City Limit
death with the	90 00	Directo	10e. Street and Number				10f. Zip C					10g. (Citizen of	What Co	untry?
ath w	Tan I	E	4901 York Road	10 11 - 0 - 1 - 1 - 1	- 110	1 40 11		212		: 2 (2			S.A.		
ē 2	9	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1	Yes, specify Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or N Rican, etc.)	0-		ck, White	ican Indian, o, etc. Lack
21215-0036 ad within 72 hours aff rgiene. er then "netural", or	Polical	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		Sa. Decede (Give k life. D	ent's Usual (ind of work of ONOT use	Occupa done di retired)	tion uring most	t of worki	ηg	16b.	Kind of B	lusiness/l	ndustry
aryland 2121. should be filed within and Mental Hygiene.	event, I're M	E O	Elementary/Secondary (0-12)	College (1-4or 5+	-)		mesti					P	rivat	te Fa	mily
e filec othe	vent,	De C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maide	en Sumar	пө)	
Vlar Mente Mente	atic.	0	George E. Thomas						Mar	y Sa	yles				
Maryland od 2 should be file tth and Menta! Hy 27 is marked oth	other traumatic	1	19a. Informant's Name/Relationship (T			_					I Route Numb				
	thert	1	Alice E. Jackson 20a. Method of Disposition		20b. Place	of Dispos	ition (Name	of			., Bea	,			C/IZ Town, State
MO Page ent o	See		1 ∑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License)	St.	James Ch Ce	Bapt meter	r <i>place</i> ist y		7/16	/05		aleto		
Baltil Permit. P Departm Importer	any ir		21. Signature of Furneral Service Licens) Il face		J	oynes	Fur	neral	Hom	e Inc.				
death certificate be executed my least to entered my least my leas	ner neusit	=	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tary, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a INFEC Due to (or as a Due to (or as a Due to (or as a d.	consequence TED	BRE	EAST		M AS	SS					Onset and Death
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ecords, P.O law requires that the			Part II. Other significent conditions co	ntributing to death but	not resulting	j in the und	derlying caus	se giver	n in Part I.			tobacco Yes 2		ribute to	the cause of death?
~ 0 =	page 2 should	completed by	HYPERTENS	10N										death?	opsy findings available ompletion of cause of
Vital F sicien: Th certificate	d lo	וע	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		0	103	26,110
of Vita Physicien: rthis certific	al director,	2	examiner?	Hospital: 1 Inpatient	2 □ EP/0	Outpatient	3□ DOA	Other	4 □ Nui	rsing Hon	ne 5□Resi	dence	6 □Oth	er (Speci	fy)
Vision o Attending Pl r death. ector: After th	led in by the funera		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Ye <i>ar)</i> 28b	. Time of Injury	28c.	Injury a Work? 1 □ Ye	at ? es 2 □ N		8d. Describe	how inj	ury occur	red	
Divis	d in by		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stree	et, factory, o	ffice		2	8f. Location (City or To	Street a wn, Sta	nd Numb te)	er or Run	al Route Number,
Division To the Hospitel or Attendition 24 hours after death To the Funeral Director:	completely filled in by the funer		29a. Certifier 1 ertifying Phy cone) 2 Medicel Exami	sicien: To the best of ner: On the basis of e and manner state	xamination a	ge, death o	occurred at to	the time my opi	nion, deat	d place, a h occurre	nd due to the d at the time,	cause(: date ar	s) and ma	anner as s and due t	stated. o the cause(s)
To th within To th	dwoo		29b. Signature and title of certifier Signature and title of certifier	Som N	10				number	0					Day, Year) 2005
1	γ		30. Name and address of person who co		ath (Item 23a		rint) VEN								
	State		31. Date filed (Month, Day, Year)	32. Bagistrar		-						-			

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DEMBY, VIVIAN